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PUBLIC HEALTH THE PRODUCT OF INDIVIDUAL PREVENTIVE MEDICINE*

HAVEN EMERSON, M.D.
NEW YORK CITY

High is the purpose and fortunate the occasion when men and women gather to pay a tribute of attention to that incomparable treasury of knowledge, preventive medicine, which holds the power of making human life a triumphant experience in happiness.

You, here in presence, whether disciples of that practice of human biology which we call medicine, or representatives of the households of Michigan, and your innumerable fellows in hospitals, offices, cities and farms of this far flung state, are all for this brief period concerned with the use and value, the method and purpose of those sciences and arts upon which a great share, if not the whole substance, of our social survival now depends.

History teaches us that at least three kinds of efforts to control man and his society, his aggregate or collective existence, have swept over the world, and even while we hold our breath a repetition of the cycle seems imminent. Force of arms, spiritual revolution, and commerce has each in turn possessed itself of the bodies and souls of men. Of the military empires from earlier centuries none remain. The dynasties of religion play an ever shrinking role where once they dominated human conduct. We are in the very midst of that collapse of international commerce, and almost of that personal trade which lives by fair return for honest labor, which for the last hundred years have been the working philosophy of men and nations, the economies and sociology of a Victorian and pre-war civilization.

Are we to watch, fascinated and inactive, a new onslaught by state or race upon man's potential development, a direct attack upon his social and self-determination, a blocking of his progress towards higher attainments of body and mind for his family and his future?

Our answer to the threat of wars of aggression, to the temporal empires of religion, and to the conflict between capital and labor, government and industry, producer and consumer, can perhaps contribute something helpful.

Medicine is but the name of a vast trusteeship built upon the searching and answers which men of all centuries have recorded in matters of human life. First, and inevitably so, was the study of sickness, pain, misery, of body and mind. The heart and compassion of his fellows could but respond by efforts at relief of suffering.

*The Andrew P. Biddle Oration in connection with the Annual Meeting of the Michigan State Medical Society for 1938 was delivered by Dr. Haven Emerson of New York, on September 21. Dr. Emerson was introduced by Dr. Angus McLean. Following this lecture, Dr. Emerson was presented with the Biddle Oration Scroll. The lecture was very well received and now that we are privileged to give it a permanent place, we recommend that it be read not only by those whose good fortune it was to hear it, but by those members of our society who were unable to be present.—EDITOR.

Out of this has come 2,300 years of the traditional practice of medicine, a history of uneven progress towards that, so great but still only partial, measure of present success in diagnosis and treatment of disease, which demands the most rigorous discipline of education and most intimate and confidential reciprocal relations between patient and physician, both precious and respected.

Medicine Preventive Rather Than Curative

For not more than a hundred years medicine has engaged in an application of its accumulated experience with the natural history of disease, for the purpose of preventing those illnesses for which the cause was both known and controllable. So rapidly have physicians and their collaborators among the biologists, chemists, physicists and sanitarians added to the list of preventable diseases that it is now a question whether a larger fraction of the available personnel of the medical and associated professions is not actually devoted to the control of these than is engaged in the cure of the sick. What was but a few decades ago the interest of a handful of investigators or officers of departments of health is now the preoccupation of a growing army serving science, society, and the individual, industry, government and the family for the protection of the health of man. Never before were such sums devoted by taxpayers, by philanthropy and education, by industry and commerce, to the advancement of our knowledge of preventable disease and to the practical application of this in the saving of life. But even such advance from care of the sick to prevention of disease neither satisfied the ambition of students of the medical sciences nor checked the progress of ideas towards an even more influential field of effort, that of creative medicine, the development of health, not only safeguarding what we have but taking steps to improve upon it. Conscious determination to add to the sum, duration or quality of human health could hardly fail to follow the phenomenal mastery over the living plants of field, farm, and garden, the animals of burden, sport or food which the biologists have achieved. It was not enough that man could control his environment and his nurture, but he must take thought also of his nature, his origins, the living sequence of his own qualities and the significance of these for the following generations. So, although this is still preventive medicine, it is at another level, contemplating in its scope the use of man's highest mental and spiritual qualities of self-control and of creation. Included within the field of such creative medicine is what Galton defined as eugenics, "the study of agencies under social control that may improve or impair the racial qualities of future generations either physically or mentally." In other words, medicine of today acknowledges its concern with heredity as a practical factor, to be dealt with in the interest of health, and as a means of preventing disease.

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How then is medicine prepared to meet the challenge, to carry into the realm of accomplishment the resources it now holds for man's benefit? Is it necessary or desirable to transfer unto government those functions and relationships now possessed by the physicians? What are the activities contributory to health which can be carried on only by government? What is the necessary share of the individual whose health we seek to benefit? Is there one plan for national health that will meet the pattern of thought of each community in the varied mosaic of our nation, and who shall do the planning?

These and similar queries must be answered before we can acquire a sense of direction in our further quest for the Grail of Health.

* * *

Since the development of creative or eugenic medicine is still in the stage of intellectual and social exploration, and with a few exceptions hardly yet comes within the range of general application, we can best analyze the situation under the two main divisions of so-called curative and preventive medicine, both of which are best applied through the ministrations of the private practitioner of medicine.

Distribution of Medical Care

For the diagnosis and treatment of the sick the only serious criticism sustained by reasonable evidence is that the physician does not automatically seek as places for residence those areas or communities where the people are too poor to meet his reasonable expectation of a livelihood. Remedy for this is either social or governmental guarantee or subsidy to the physician of an income sufficient to attract one of suitable

qualifications to these relatively less promising localities. True, there is a small fraction (about one and a half per cent) of the population not yet within an hour's motor ride, or thirty miles, of an approved hospital, and in some instances the hospital nearest may not be prepared to meet the needs of the patient at hand. Tax money may be justified in increasing the availability of hospital care of an acceptable character to all but the most remote and lonely dweller of our population. It is not an organization of physicians to serve, nor their regimentation by government that is needed to remedy the present inequalities of their distribution, but the facilitation of the necessary habits of organized thrift and forethought among the people which will make it possible for the family, or the group, or if necessary the community, to pay for the cost of sickness which would be beyond the means of the individual to meet. The medical profession is committed to a policy of high standards of education and licensure, and of a method of professional self-discipline and a quality of performance which is not likely to be bettered by vesting such responsibility in officers of civil government.

There are eight subdivisions of institutional care of the sick which society, at least in our large, and in many of the better organized smaller cities and adjacent counties, has found necessary or desirable in the interest of medical efficiency and economy, and these have the approval and active coöperation of the participating physicians, and could not have survived unless they had proved their practical necessity, and staff standards of professional conduct were in effect. To list these forms of institutional care of the sick will suffice for such an audience as this. The hospital, the out-patient service, visiting nursing, medical social work, ambulance service, the convalescent home, the hospital for the chronically ill, and home medical care for those eligible for but not requiring free hospital care. These institutions and agencies representing organized care of the sick, together with the services of the individual practitioner of medicine, have achieved an extent and quality of medical services in this country which have not in the past been available or equalled for any similarly extensive or varied population in other continents. This has been achieved without hardship to the sick or to the taxpayer and without creating abuses of monopoly or privilege leading to excessive incomes among physicians. Admittedly imperfect in quality and quantity for certain fractions of our national population, medical care in sickness is likely to continue its really remarkable improvement of the past half century better by reliance upon the forces inherent in the medical profession and by the reasonable demand of patients and their families than by the intervention of the interests of government or by the proposals of economists, sociologists and politicians.

Responsibility of Laity

For the prevention of disease and the protection of health there are many shortcomings in our plans and performance. These can honestly be laid to the door of the laity rather than be charged against medical incompetence or unwillingness. And yet by any measure we can apply through historical comparison or contemporary statistics we do now appear to be at the very zenith of a period of amazing improvement in health. In fact, never before has any substantial part of our population, nor has at any time in the recorded history of man, any population of such size, diversity of racial, climatic and social conditions in any other continent or under one government been so relatively free from communicable disease, so likely to have its children survive the hazardous years of infancy and early childhood, or to so nearly approach the biblical term of years of life.

If, as the spokesmen and women of technical committee and interdepartmental board in Washington have recently announced "the facilities for public health are grossly insufficient," it may be well to remind them that it is not by their efforts that we have reached the summit of the foothills of health, and that less extravagance of statement would better become a federal government which now offers little new to us, other than to put our children and grandchildren more deeply into debt for their health, so that it, the present federal administration, may claim merit for doing suddenly and at great cost, what society and medicine have been achieving slowly, steadily and surely within the means of thrifty communities to pay as they go. True there are mountains of unnecessary disease and human suffering to be tunnelled, scaled, or worn down by the gradual erosion

of scientific progress, but human biology can rarely be hurried, even by billions, and it has a way of making its more enduring advances in human survival by evolution rather than by revolutionary variants in social method.

Public Health, What Is It?

What in fact is this we speak of as public health? Is there such an entity? Is there a quality or property of societies, of units of population, of organized communities which we can describe as public health? Or are we using a term which diverts us from the understanding of the truth, while catching the ready ear of the unthinking throng?

Health is individual, personal, a quality of man, of his wife, of their child. It is what the person, within the limits of his inherited qualities, achieves through adaptation of himself to his environment, both social and material, and by the molding of his surroundings to the purposes of his own life. There may be as many ways of being healthy as of being sick. There is no one pattern for all persons, even for the two sexes, or certainly at all ages, for the achievement of individual health. It is an experience with life, not a static something to be had, held, given away, bought or sold.

Health is much more than the freedom or recovery from disease. It is a way of life, a balance, a compromise sometimes, worth sacrificing other desires or ambitions to achieve, and the most precious possession a person may lose or feel compelled to give up in exchange for other ambitions. The philosopher has said, "Give me health and a day and I will make the pomp of Emperors ridiculous." That is a quality of man the individual, not of that amorphous, helpless, blundering social entity, the Public.

What then does the public health department do if not give the public what it pays its taxes for?

As for the care of the sick we have the physician and the institution, so we find the family physician and the health department inseparably involved in an indispensable collaboration to the same end, that each person in the community may be spared avoidable handicaps of infection, nutrition, occupation, growth, development, personality, body and mind, and be so guided and guarded through the amazing experiences and complications of life among his fellows that he wins his goal, whatever that may be for him, without violating the inexorable laws of human biology and so paying the penalty of ill health.

There are but six functions which modern civil government has found appropriate and necessary for a department of health. Whatever nation, state, city or rural area has created a department of health to be devoted to the application of the science of preventive medicine for social ends, it has found that vital statistics, communicable disease control, the hygiene of maternity, infancy and childhood, laboratory service, sanitation, and health education include all essential public health services. These are all auxiliary or supplementary activities, the benefit of which comes to the client or patient of the private practitioner. Each of these functions of a public health department is necessary to make more effective, not to supplant, the work of the family physician.

Government Functions in Health Affairs

Think of these public functions in turn. Only government can require the reporting of births, deaths and their causes, and then analyze, interpret and publish them for the better understanding of the phenomena of living and dying, the facts of original record provided by the physician.

Only government can be trusted with the broad powers upon which communicable disease can be controlled. And yet at every point in the process of such control, be it by isolation of the sick, immunization of the susceptible or development of resistance against infection and establishment of full recovery from it, it is upon the family, the individual and their chosen physician that the actual service should and does fall.

For the hygiene of maternity, infancy and the child, if we had a consistently educated community of families, there would be no need for concern of the health officer with such matters. It was only because families and their physicians appeared a couple of decades ago unaware of the potential benefits of prenatal and infant care, of supervision of the pre-school and school child, that the health officer had to use his authority and the pulpit of his position to persuade people of the meaning, need and value of these, and lead the physician to a broader way of private practice by including them in his services.

To the obstetrician and pediatrist the Health Officer owes a particular gratitude for taking on his struggle before the medical profession. Certainly no public officer, elected or appointed, can be presumed to have such interest or responsibility for the health of the expectant mother as she herself and her husband should have, and should know enough to ask for from their physician. It is not that the care of the maternity patient, or the management of the infant, the examination of the runabout child or the direction of the way of life of the school child is an exclusive or wholly proper duty of the Department of Health, for it certainly is not, but the Health Officer must concern himself to see that every expectant mother knows what she ought to have in the way of guidance during her pregnancy and how this can be assured for her. It is not the function of a health department to become the community midwife, wet nurse or diaper expert, but by its persuasive and objective teaching it can bring it about that every mother and child receives such advice in the physiology of human development that growth may be uninterrupted and both mother and child may survive for their mutual advantage.

The necessity of a subdivision or bureau of the health department devoted to child hygiene and maternity is due to the age-old habit of people to think of the physician as a "sick doctor" to be called upon only when fear, or failure of home remedies, demands help. It ought to be as much taken for granted to call upon a physician to learn how to keep a baby or its mother well as to ask him to the home to diagnose a fever or set a broken bone.

Physiological Rather Than Pathological

The first basic science training which the medical student has is in physiology, the science of the functions of the normal human body, and upon this his understanding of abnormal function or disease is built. The Health Officer of a community is its hired teacher, obliged to advertise to the public the benefits to be expected from using the local practitioner as an expert in normal childhood, as well as calling on him for medicines or operations. For thirty years before there were divisions of health departments for child hygiene and maternity, the teachers and their textbooks at the medical schools dealt expansively with the very methods of health management that are now the commonplaces of daily conferences in the private office, in the home, by doctor and public health nurse. But to reach the present still incomplete volume of use of this wisdom it has taken costly and patient repetition of advice, warning, persuasion, demonstration, actual services given free to mothers, and all the arts and pertinacity of the public health nurse, that university of health on wheels, the peripatetic teacher of family health, a very gadfly of good deeds.

As soon as the family practitioner and his patients have fully caught up with the hygienic ambitions of the health officer, and prenatal care is the rule and not the exception, and every infant has the benefit of medical supervision, then and only then can we do away with bureaus for maternity and childhood, as by that time the services will have been incorporated into the folkways of the people, and the oldest doctor will be proud of being called a physiologist, hygienist, and a health practitioner.

The Public Health Laboratory

For the public health laboratory we have but a word to say. Indispensable to the department of health for its necessary control of water, milk, foods, drugs, air, occupational hazards, etc., it serves everywhere today the highest and the most urgent needs of the practitioner of medicine as well. Whether for diagnosis or release of infection, relief from clinical uncertainty, to supply with exquisite appropriateness the immunizing or therapeutic substance, or to identify the infected or the insusceptible, the public health laboratory has raised the whole level of medical service to the sick and has vastly simplified the protection of the well. Even if under some circumstances clincial pathology can be well handled on a private laboratory basis there will always be epidemiological and control services which can be given only through such a public health agency as the laboratory of the state or city health department. The consultant position of the laboratory chief is one that could hardly be paid for at its true worth, and yet to the individual under his physician's care this costs little or nothing.

Sanitation need not concern us except to recall that environmental control, and protection of water and foods, are wholly outside the sphere of the medical practitioner.

The sanitary engineer and inspector are our professional collaborators upon whose integrity and acuteness we must wholly rely.

Medicine's Most Valuable Mouthpiece

Health education, the sixth of the major functions of health departments, is medicine's most valuable mouthpiece. Decent regard for public opinion and the esteem of his fellows forbids the physician's shouting his wares from the housetops. He knows what the people need for their health and what he could do for them if they would come to him, but he must wait in modesty of manner, albeit eager and anxious in spirit, until the patient seeks his services. Not so the health officer. He has no reticence in his pack of tricks. Publicity is his leading suit. It is not himself he is advertising, but the possibility of better health to be had around the corner at a modest price, or, if necessary, without cost. This health education is one ceaseless repetition of well known truths in new terms and colors, until the particular fraction of the public affected responds. So-called health education is intended to create curiosity and then satisfy it, to develop a motive for action and facilitate the appropriate deed. What more perfectly adapted mechanism for encouraging all persons to go to their own physician to see if what they have heard from the health officer is all so. And that is right. Whatever is said by a public officer in the United States is suspected of being partial truth, extravagance, pure buncombe or politics. Don't do a thing you are advised to for your health, whatever the broadcast or salary of the health officer, until you have learned from your own physician whether it makes sense for you personally. But the health officer who has not taken the precaution to check his projected publicity on health with the wise heads of his local medical profession and get their prior endorsement is green on his job and riding for a fall.

In fact it ought to be the medical practitioners, familiar as they are with the needs for health teaching and service among their patients, who should formulate the substance and sequence of the public educational program, and press upon the health officer to do more and better teaching, and teaching that will bring about personal health of multitudes. Some optimistic people seem to expect public health to happen automatically merely from general publicity and propaganda.

It would seem that with the possible exception in the undetermined future of the bureau of maternity and child health, and of parts of the program for communicable disease control, such as preclinical diagnostic tests and immunizations, the six standard functions of health departments are, and will remain, permanently indispensable, both to the public at large and to the members of families under private medical care.

Private Physician and Preventive Medicine

What then shall be the full duty of the private physician in preventive medicine? Will he accept the constantly broadening scope of opportunities? Will he assume leadership and be the power behind the health department? Can he re-educate himself in the eugenic implications of his knowledge of hereditary family characteristics so that his word will be listened to with affection and respect in the matters of marriage and reproduction, as it has always been in questions of obvious and present disease and disability?

When I enjoyed a fifteen year status as a family physician I dreamed that some day I might qualify for admission to that choice company whom Stevenson once so beautifully characterized.

As Health Commissioner of New York City I received the complaints and heard the undoubtedly authentic evidence from the poor and the lowly, of neglected precautions for their health by their physicians. I wondered if I could keep my faith in the honor and integrity or scientific ability of my profession. As teacher of medical students I believe I see the truth, and can speak with sure confidence of the doctor of the near future. There is no finer product of our time than the men and women who are rapidly replacing us elders in medicine. They take for granted that they have knowledge, skill and the will to use it which will be sought voluntarily by persons of all walks of life for each of the three chief purposes of medicine, to care for the sick, to prevent disease, to create now and in those to follow, a greater probability of superior health.

The present day practitioner of medicine in his private relationship to his patients owes it to them and to himself to have a

plan of professional services which will include each appropriate resource of preventive medicine for whomsoever he may be called upon to advise. This is not the occasion to offer even a list of the contents of a personal practice of preventive medicine, but there are methods and fields of service so important and inclusive that I shall venture to list a few.

The whole practice of obstetrics and pediatrics, except for the management of surgical complications and intercurrent illness, is but an opportunity to apply physiology and wholesome psychology to reproduction, growth and development.

Periodic Health Examinations

Without the use of the periodic health examination of adults, systematic protection against the handicaps of the later decades of life cannot be offered. Cancer, diabetes, heart and kidney diseases have all taught us how much can be expected by periodic medical evaluation of a person's health.

We cannot be honest with out science or our patients without the application of our resources to determine specific susceptibilities, to test the existence of certain infections, to render the individual resistant if not absolutely immune to smallpox, diphtheria, and in some areas typhoid, and to be prepared to use other active and passive immunizations for children as these prove reliable. Nutritional balance and the selection of diets appropriate to purse, work, and personal preference can hardly be attained without medical direction, at any period from cradle to old age.

Most difficult, least prepared for, uncertain of methods and results, is the gentle guidance of the spirit of adolescence into and through the urge to mate, to share true love, to mature into full responsibility and scope of an adult and balanced personality. Without intentional effort to participate in the protection of the mind, emotions and behavior by what is still so vaguely called mental hygiene, much of physical preventive medicine will be barren.

And lastly let me refer to the necessity of medical direction of the problems of fertility, sterility and eugenics, the decisions for or against perpetuating the qualities of potential parents, and the heavy social obligation of the medical profession to interpose, so far as personal liberty of patients permits, objections and effective obstructions which will cut the threads of unworthy and deteriorating inheritance. As the Regius Professor of Physic in Cambridge, England, said in the last Galton lecture:

> "If the doctor, who is already accepted as a servant, and, in some degree, as an instructor of the people, is enabled in course of time to state authoritatively that certain eugenic principles are not only sound but practicable, he will soon be given a hearing not only by his patients but also by statesmen—a hearing which non-medical eugenists, often far better informed but lacking the doctor's personal contacts and sphere of influence, have sought in vain."

Public health, compounded of private guidance of individuals and the social use of governmental services, means all these visions of human improvement. To bolster my own fond hopes with the opinions of those with wider experience and more responsibility let me quote from an influential committee report from Great Britain: "We regard it as of primary importance that the organization of the health services of the nation should be based upon the family as the normal unit and the family doctor as the normal medical attendant and guardian. It is not for disease that provision has to be made, but for persons liable to or suffering from disease. The first essential for the proper and efficient treatment of individual persons is therefore not institutional but personal service, such as can be rendered to people in their own homes, only by a family doctor who has the continual care of their health; to whom they will naturally turn for advice and help in all matters pertaining thereto; who will afford them such professional services as he can render personally; and who will make it his duty to see that they obtain full advantage of all the further auxiliary services that may be otherwise provided."

And I shall venture another quotation from an eminent Britisher, Sir George Newman, until recently and for many years the chief medical officer of the British Ministry of Health, in discussing governmental medical services for health, who gave his opinion of the contribution of the medical practitioner which applies equally to the situation in many, if not in all, parts of the United States today.

> "The work of medical practitioners has not only saved life on a scale undreamt of a hundred years ago, but it has made living a better thing. Much of their teaching has now passed beyond the control of a profession and has entered into the common knowledge of mankind, forming, indeed, part of the very laws and customs of civilized nations.

It was the doctors who taught us the characteristics of a sanitary house, of the necessity for a pure and sufficient water supply, of the advantages of drainage, of the ingredients of a wholesome dietary, of the infectious nature of certain diseases, of the principles of personal hygiene—now all matters of common knowledge."

With these principles not only in mind but in current practice in this city of Detroit to a notable degree, and elsewhere in rural counties of this state, I believe it well for us to be alert to the interests of the public and our profession lest under the pressure of some governmental inclination to take sudden and unwise action we find ourselves hampered by the persuasive power of federal grants to undertake programs inconsistent with experience, and both untimely and immature.

What we need is more intelligence, some patience, and much good-will to bring the full benefits of preventive medicine to our people, more than money borrowed from the future. Errors of economic theory and practice can easily so shackle us and our successors that relief from some of the still lingering preventable diseases will seem to be but small return for our accumulated indebtedness.

There are two great Michiganders to whom in closing I wish to pay my respects, men of medicine whose vision, courage and resourcefulness made a notable record of wise public action for health in this state, and influenced the progress of preventive medicine far and wide. I refer, of course, to Drs. Henry B. Baker and Victor Vaughan. These men saw in their day, as their successors in private and public life do today, that the full value of the well established facts of preventive medicine depend upon an alert and informed laity, a competent body of private practitioners of medicine in all its stages, and public service for health which will do for the community what the individual physician cannot do alone for the public as a whole.

As in fact most if not all the original contributions to the science and practice of preventive medicine have come from the hand of the general practictioner of medicine and from the laboratories of our institutions of higher education, so the universal application of organized services for the betterment of human health will be built, as we now see it developing, upon the services sought from and provided by the family physician, supplemented and greatly reinforced by the indispensable services of the local and state departments of health.

THE USE OF CRYSTALLINE INSULIN IN THE TREATMENT OF PATIENTS WITH SEVERE DIABETES*

SAMUEL S. ALTSHULER, M.D., F.A.C.P.
and
RUDOLPH LEISER, M.D.
DETROIT, MICHIGAN

During the past two years we have had the opportunity of using crystalline insulin (Stearns) in the treatment of 150 diabetic patients. We first became interested in this product on account of its purity. Our earliest studies[3] revealed that crystalline insulin has a slow action and a prolonged effect on the blood sugar, and that in the treatment of diabetes mellitus the blood sugar levels could be better controlled with fewer doses and with fewer total units than was possible with unmodified (regular) insulin. These observations have been corroborated by Freund and Adler,[6] Mains and McMullen,[7] Barach,[4] Allen,[1] and most recently by Shepardson and Friedlander.[10]

Crystalline insulin was then tried in the treatment of diabetes mellitus associated with various complications,[2] in patients ranging from six to eighty-six years of age. After a year's experience with 100 patients, sixty-one of whom manifested some type of complication or associated condition, it was found that this insulin could be used successfully in any type of diabetes requir-

*From the Departments of Internal Medicine, William J. Seymour Hospital, Eloise, Michigan, and Wayne University College of Medicine.
Read before the Section on Pharmacology and Therapeutics, at the Annual Session of the American Medical Association, San Francisco, California, June 15, 1938.

TABLE I. PATIENTS REQUIRING 20 UNITS OR MORE

Age Group	One Dose	Two Doses	Total	Total Patients in the Age Group
1-15	1	3	3	5
16-30	0	17	17	19
31-45	1	17	18	19
46-60	11	31	42	67
Over 60	0	18	18	40
Totals	12	86	98	150

TABLE II. PATIENTS PRESENTING SPECIAL PROBLEMS

Age Group	Insulin Sensitive	Complications	Total Patients in the Age Group
1-15	4	1	5
16-30	11	6	19
31-45	5	9	19
46-60	5	46	67
Over 60	1	30	40
Totals	26	92	150

ing insulin, with the possible exception of diabetic coma, in which condition it was not tried.

Since that time special attention has been given to the study of patients with severe diabetes, and the present report is based upon experiences with crystalline insulin in such patients, some of whom have been using this preparation continually for two years. For purposes of this study, severe diabetes is considered to include one or more of the following criteria: (1) The patient requires more than twenty units of insulin daily; (2) the patient is the labile insulin-sensitive type; or (3) the patient has an associated complication.

The first group is merely an arbitrary standard for consideration here (Table I). There were ninety-eight patients in this group, of whom eighty-six required two doses of insulin daily while twelve were able to get along with one dose daily.

The second group, comprising the insulin-sensitive patients, has always been the most difficult to keep under constant control (Table II). The third group is included because the mildest diabetic patient who develops a complication, such as an infection or gangrene, becomes a severe diabetic from the standpoint of treatment. It is interesting to observe that of the 26 insulin-sensitive patients by far the greater number occur in the early age groups and in fact comprise a very large percentile part of these groups, whereas the patients with complications make up the greater part of the late age groups. Table III presents the types of complications and associated conditions which were encountered. Some of these patients were treated in the hospital as in-patients, some were treated in the clinic as out-patients, and the rest were private patients seen in the office. All of these patients were well controlled with crystalline insulin, the criteria of diabetes control being (1) aglycosuria throughout the twenty-four hours, and (2) blood sugar levels between 70 and 180 mg. per 100 c.c. The blood sugar levels between 120 and 180 mg. per 100 c.c. are apparently better tolerated by patients with severe cardiovascular disease than the lower ranges. Blood sugar studies were made at periodic intervals throughout the twenty-four hours, usually at 5 and 10 A. M., 3 and 7 P. M. and at 12 o'clock midnight. A fasting blood sugar alone is insufficient evidence of the true range of blood sugar level throughout the twenty-four hours.

TABLE III. TYPES OF COMPLICATIONS

Infections
- Respiratory
- Syphilis
- Tuberculosis
- Osteomyelitis
- Ulcers of leg
- Carbuncles
- Infected wound

Eyes
- Cataracts
- Acute iritis
- Neuroretinitis with blindness

Endocrine
- Hypopituitary
- Amenorrhea
- Pituitary dysfunction
- Hyperthyroidism

Gastro-intestinal and Biliary
- Peptic ulcer
- Catarrhal jaundice
- Cholecystitis

Neurological
- Diabetic neuritis
- Epilepsy
- Parkinson's disease
- Neurosyphilis
- Ophthalmoplegia
- Senile dementia
- Psychosis

Cardiovascular
- Hypertension
- Cerebral hemorrhage
- Cerebral thrombosis with hemiplegia
- Coronary thrombosis
- Heart disease
  - Hypertensive
  - Arteriosclerotic
  - Rheumatic
  - Paroxysmal auricular fibrillation

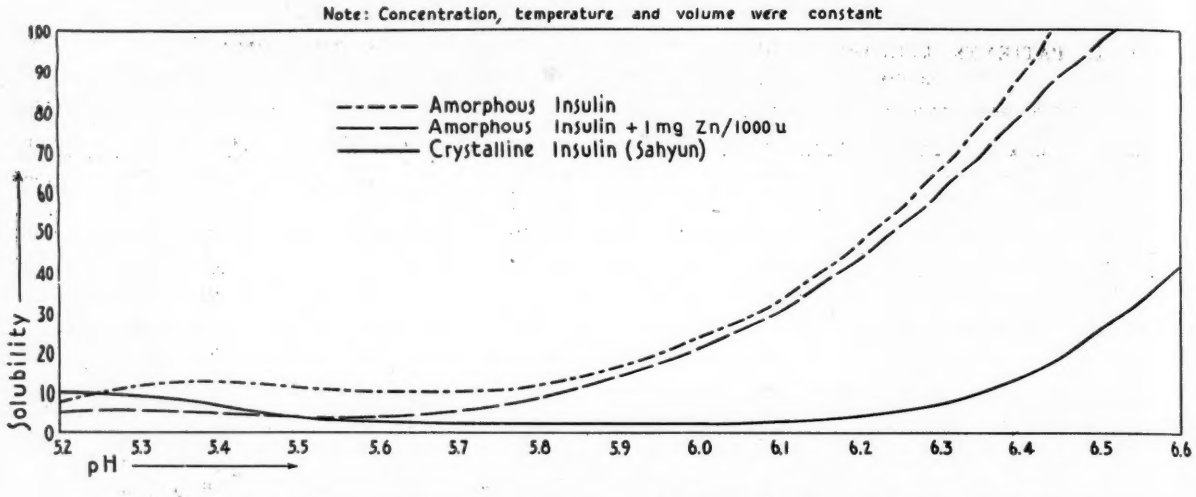
Peripheral vascular
- Gangrene
- Buerger's disease

Skin
- Psoriasis
- Squamous cell epithelioma

Genito-urinary
- Orchitis
- Prostatitis
- Uremia

Other complications
- Fracture
- Asthma
- Arthritis
- Pregnancy
- Pre-operative and post-operative
- Acidosis

Crystalline insulin is administered subcutaneously in one or two doses daily. The morning dose is given one-half to one hour before breakfast, and the second dose, if it is necessary, is given about ten to fourteen hours later, either before or after the



SOLUBILITY OF CRYSTALLINE, AMORPHOUS (UNMODIFIED) AND AMORPHOUS + ZINC (1 MG. PER 1,000 UNITS)

Chart 1. Crystalline insulin and amorphous insulins do not yield the same solubility curves on the alkaline side of their respective isoelectric points. Crystalline insulin is less soluble than amorphous insulin with or without added zinc at acidities ranging from pH 6.0 to pH 6.6. (This chart reproduced through courtesy of Dr. Sahyun.)

evening meal. The change from unmodified to crystalline insulin is very easily accomplished. The patient is started on 75 per cent of the total units previously taken, divided into two doses. Each dose is subsequently adjusted according to fractional urine examinations. For a patient who has never taken insulin and who does not have any complications it has been found best to start with an arbitrary amount of from 20 to 30 units divided into two doses and to adjust each dose as indicated. Should the patient have an infection or an acidosis, the starting amount must be somewhat larger—40 to 50 units, divided into two doses. It seems obvious that prolonged-acting insulins are not suitable for the treatment of diabetic coma because this condition is a medical emergency and requires the most rapid-acting insulin available.

In arranging diets for patients using crystalline insulin the total available glucose is divided into three equal parts. In 5 to 10 per cent of the patients—usually those in the insulin-sensitive group—it has been necessary to give an additional 100 to 200 grams of milk four hours after the evening meal.

With crystalline insulin, local reactions have been very rare even among those patients who manifested marked reactions to other insulins. Meyers[8] reports a patient who was reacting with giant hives to unmodified insulin but who has been able to take relatively large doses of crystalline insulin without any local reaction. In our group there were several patients with lipodystrophy at the site of unmodified insulin injections. The use of crystalline insulin by these patients for two years has not produced these atrophic deformities of arms or thighs.

General allergic reactions with diffuse urticaria occasionally occur with the use of unmodified insulin. Foster[5] reports the case of a diabetic patient who was in acidosis and to whom it was consequently necessary to give large doses of insulin. The administration of unmodified insulin caused a severe generalized urticaria, and the intravenous administration of this insulin brought about severe allergic shock which necessitated adrenalin for relief. With all this, the patient seemed to be refractory to unmodified insulin; the acidosis was not relieved and the CO_2 combining power went down to 10 per cent. The patient was then given large doses of crystalline insulin, which relieved the acidosis and did not bring forth any allergic reaction.

The incidence of hypoglycemic reaction has been less with crystalline than with unmodified insulin, and these reactions, when they did occur, were not associated with as severe shock. Hypoglycemic reactions due to crystalline insulin are relieved by the administration of one teaspoonful of Karo syrup or sugar with one-half glass of milk. This is repeated in 15 minutes if necessary, and if the symptoms have not abated within half an hour 50 per cent glucose is given intravenously. Milk is given with the sugar

in these reactions because of its protein content which takes care of the prolonged action of the insulin. The time when an insulin reaction may occur is definitely predictable because the duration of action of crystalline insulin is constant in a given patient, and the potency does not vary.

I am indebted to Dr. Sahyun,[9] for the following chemical data and the explanation of the mechanism of prolonged hypoglycemic effect of crystalline insulin:

"The crystalline insulin which has been used in this study has a zinc content of not more than 0.04 mg. per 100 units, a nitrogen content of approximately 15 per cent, and ash of approximately 1.5 per cent or less; it has been found to assay 22± units per mg. This insulin is remarkably stable, having been kept at a temperature of 40° C. for 16 months without any loss of potency.

"Chart I shows the comparative solubility of unmodified, or amorphous insulin, and crystalline insulin at the various pH levels. Crystalline insulin is less soluble than amorphous insulin at acidities ranging from pH 6.0 to pH 6.6. At about pH 6.6 amorphous insulin is entirely soluble, whereas crystalline insulin is not completely soluble. This is of practical importance because the pH of insulin when it is injected is about 3.0 and the body fluids must change it to the pH of the body tissues (7.4) before it can be absorbed. Thus the diminished solubility of crystalline insulin explains its slower absorption and prolonged effect."

As we mentioned in a previous report[2] there is evidence of a possible hyperglycemic principle in amorphous insulin which is removed in the process of crystallization; this may be another factor in the explanation of the increased efficiency of crystalline insulin.

In conclusion I should like to summarize the points which seem to me most cogent:

1. Severe diabetes can be well controlled by the use of one or two doses of crystalline insulin daily.
2. The treatment of diabetes with crystalline insulin is very simple, requiring no unusual arrangement of the diet or insulin dosage. The change from unmodified to crystalline insulin can be very easily accomplished.
3. Because of the purity of the product this insulin is particularly suitable for the use of persons subject to allergic manifestations.
4. Because the action of this insulin is uniform and constant, and therefore predictable, hypoglycemic reactions can be avoided.

We are indebted to Frederick Stearns and Company for the generous supply of crystalline insulin used in this study.

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AMAUROTIC FAMILY IDIOCY (TAY-SACHS DISEASE)

DAVID B. DAVIS, M.D.
GRAND RAPIDS, MICHIGAN

In 1937, in this JOURNAL, Cooperstock[1] reported a case of this disease in a Gentile infant. Previous to his study, there had been only fifteen cases ever reported in non-Jewish children, and only three of that number had been examined postmortem. The early recorded observations of amaurotic (ἀμαυρσείν = to darken, blindness) idiocy gave the impression that the disease was distinctly familial and confined to Jews, especially Polish Jews, but later reports have shown that "it is not rare in Hebrews of other nations, and may occur in non-Jews."[5]

From the first three to nine months of life, the infant is apparently normal. Then it begins to show a general weakness, is unable to move its extremities properly or hold up the head, and finally, even with support, is no longer able to sit up. About the time that the weakness makes it appearance, the vision begins to fail and the baby becomes

sensitive to sound and touch (hyperacusis). Even the slightest stimulus may be sufficient to throw the child into a position of decerebrate rigidity or generalized convulsions.

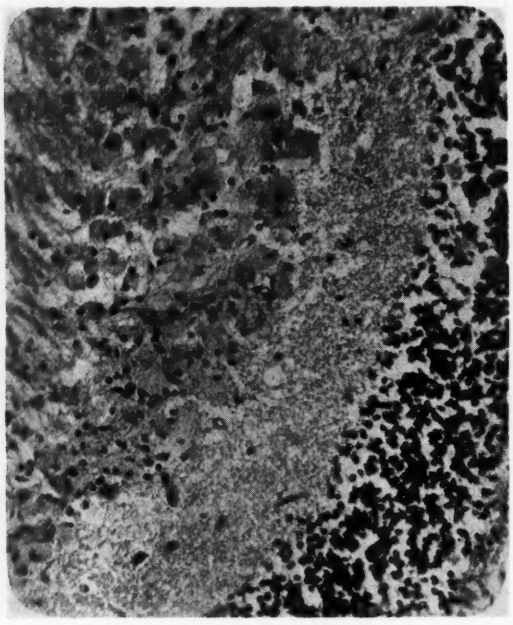

Fig. 1. Retina showing ballooning of ganglion cells. Hematoxylin and eosin stain. ×250.

At first, the muscles are soft and flabby and later in the illness may show atrophy. The tendon reflexes are absent or diminished, but it is said that they may be normal or exaggerated. The ophthalmoscopic examination will show the characteristic cherry-red spot, surrounded by a white halo, in the macular region, and there is always a concomitant optic atrophy. As the blindness increases, the pupils become dilated and fixed to light. Occasionally, there is nystagmus and extraocular palsies.

As the general weakness increases and the blindness progresses, the child fails mentally. It is no longer able to say simple words, play with toys, nor show any interest in its surroundings. The course of the disease is such that the child finally becomes a vegetating idiot and dies of general weakness or some intercurrent infection before the end of the second year.

Because amaurotic family idiocy is one of the few diseases of the brain to show specific ganglion cell changes and because these changes are so striking, much attention has been given to the study of the pathology after fixation and staining. The usual methods of fixation limit the study of lipoid, or fat-like, substances. Unfortunately, we too began our study after fixation with formalin, so we can add nothing as to the true nature of the fat-like material. Our observations of the eye help to substantiate the explanation of Pointon, Parsons, Holmes,[4] and Hassin,[3] as to the cause of the cherry-red spot, and our notes on therapy may be of value in further study of treatment.

Case Report

A baby girl was first seen on April 14, 1937, at the age of sixteen months. A study of the family history on each side for three generations did not reveal any similar case. The parents were of American extraction and there was no consanguinity. The patient was a full-term baby, weighing eight pounds, and the mother was well all during the pregnancy. At the age of two and one-half months, the child had pneumonia followed by full recovery. When six months of age, she could say single words, such as "Mama," "Dada," and "Oh Boy." At nine months, she could sit up. Soon after this time, the child's weakness became apparent as she could no longer sit up without support, and, at one year of age, she was unable to hold her head erect. Though the parents believed the child did not see well, they did not have a medical examination until she began to have convulsive seizures at the age of sixteen months.

Examination.—The child was held by the mother as she was unable to sit alone or hold up her head without support. The muscles felt soft and there was a complete absence of all deep reflexes. An examination of the fundi showed a bilateral white optic disc and a cherry-red spot, surrounded by a large white halo, in the macular region of each eye. Sensitiveness to sound (hyperacusis) was especially marked as the slightest noise would cause the child to start suddenly. The spleen and the liver could not be palpated.

Roentgen Ray Findings.—Chest studies were normal. Skull: The anterior fontanelle was rather large and was not closed. The forearms, legs, and pelvis showed a slight amount of rickets to be present.

Laboratory Findings.—Red count: 4,830,000; hemoglobin, 13.7 grams; white count, 7,550. Differential count: Polymorphonuclears, 48; lymphocytes, 50; basophiles, 20; polymorphonuclears, filamented, 27 and nonfilamented, 21. Blood Kahn tests on both mother and child were nagative. Blood sugar was 52 milligrams; blood calcium, 10 milligrams; blood phosphorus, 2.8 milligrams. Splenic puncture findings: Although there was no spleen nor liver enlargement clinically, a splenic puncture was performed by Dr. Donald Chandler and the material was examined by Dr. W. P. L. McBride, who, after study by the usual staining methods, considered the spleen to be normal.

Treatment.—The treatment to the present time has been purely symptomatic and, as endocrine preparations have been used by others without success, we decided to use vitamins although there was no definite indication for such therapy. From April 21, 1937, until August 2, 1937, the infant was given Natola (Parke Davis and Company), ten-drop doses twice each day, for its vitamin A and D content, and vitamin B extract, or "complex," as it is sometimes called (Parke Davis and Company), one teaspoonful twice each day. The vitamin administration had no effect on the course of the disease.

Course.—During the next few months, she became weaker and had more frequent convulsions. Various stimuli, such as a loud sound or a sudden jarring of the bed, would cause a convulsion. At other times, she would become rigid all over for a few moments without any convulsive movements.

The appearance of the cherry-red spots did not change, but the optic discs became entirely white, the pupils dilated and fixed, and, for the last two months of her life, she had a horizontal nystagmus.

In the first week in June, she began to have difficulty in swallowing and developed a stridulous breathing. She became gradually weaker and died on August 12, 1937.

Postmortem studies were made by Doctor William M. German. There were no abnormalities of the external surface of the body nor of the internal organs. Normal cellular architecture of the spleen and the liver was not disturbed and there were no fats within the cells.

The external configuration of the brain was normal. On microscopic examination, the ganglion cells of the cortex of the cerebrum and the cerebellum presented the usual changes found in amaurotic idiocy; that is, the cytoplasm was ballooned greatly, the nucleus was eccentric and in many cells it had disappeared. The Nissl bodies were either absent or crowded to one pole of the cell.

The ganglion cells in the retina of each eye presented the same changes as the cortical cells of the central nervous system (Fig. 1). In the retina, the greatest number of ganglion cells is found in the region of the macula and their destruction and swelling is the cause of the white halo. The cherry-red spot is due to the normal red color of the fovea centralis, which is practically devoid of ganglion cells and therefore does not undergo the changes that are seen in the cells in the remainder of the retina.

It was not possible to stain the fat-like material in the ganglion cells of either the brain or the retina with osmic acid.

Except for a slight increase in the number of glia cells, there was no marked change in the white matter of either the cerebrum or cerebellum.[2]

Comment

This report of a case of infantile amaurotic family idiocy in a Gentile brings the total number of such cases reported to seventeen and the number of autopsy descriptions to four. Although we were unable to add anything new concerning the pathology, we hope that our observation will stimulate others to study fresh material before it has been placed in formalin. In this way, someone may come nearer a solution of the question as to the nature of fat-like substances in the degenerated ganglion cells.

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ELECTRENCEPHALOGRAPHY: INTRODUCTION AND PRESENT STATUS*

A. J. DERBYSHIRE, Ph.D., and S. STEPHEN BOHN, M.D.

DETROIT, MICHIGAN

The electrencephalograph is in its essentials a machine similar to the electrocardiograph although by use of modern audio-amplifiers a greater sensitivity to small voltage fluctuations is achieved. The apparatus is designed for amplifying and recording the small oscillating changes of voltage that can be led from the surface of the human scalp. Berger, in 1929, started a description of the records in normal and abnormal individuals which he has continued up to the present time. His energetic work has given a new impetus to the medical application of an old line of research that began in 1874. His genius has also offered us many clues to the significance of these phenomena.

A suitable type of active electrode and one which we are using at the present time consists of a small flat lump of solder, five millimeters in diameter, applied to any place on the scalp that has just been cleansed of its oily film by acetone. The hair need not be removed. A small dab of electrocardiograph paste between the solder lump or electrode and the scalp keeps the skin resistance at a low value (2,000 to 10,000 ohms). A coat of six per cent collodion that has dried thoroughly will hold the electrode in place and will keep the electrode paste from drying. The solder lumps are connected to the leads of the amplifying apparatus by a short length of fine enameled copper wire. Davis[12] proposed, as a standard procedure, that a similar lead on the

*The apparatus for this work in electrencephalography was supplied by Wayne University, College of Medicine, while the facilities for the pursuit of this research were granted at Harper Hospital through the courtesy of Dr. Hugo A. Freund.

ear or the skin over the mastoid process will act as an indifferent electrode to which the activity picked up by the electrode on the scalp can be compared.

Differences in voltage occurring between the electrodes on the scalp and on the ear are normally between 20 and 100 microvolts. With the use of a shielded audio-amplifier that will not distort the form of these voltage changes in either the time or voltage scale, these differences of potential can be amplified to a magnitude that will activate an accurate although relatively insensitive recorder. We have in use a capacity coupled, push-pull amplifier built by Albert Grass of Quincy, Massachusettes, which is capable of about one million-fold voltage amplification and has an overall time constant of about 0.1 second. For a recorder we use an ink-writer capable of transmitting frequencies up to 80 cycles per second without distortion. It delivers on moving paper tape a permanent record of voltage change with time. Fortunately for clinical work such modern recorders produce an easily readable record during the examination of a subject so that a preliminary interpretation is possible at once.

With more than one amplifying and recording unit several places on the head can be studied and compared simultaneously. This is often important in determining the point on the scalp which is first to show an abnormal pattern. Such an area may then be considered as the origin of the disturbance.

The standard electrencephalogram is taken under a particular set of conditions originally used by Berger[4] and recently emphasized by Davis.[12] The subject should be as comfortable as possible and in a state of physical and mental relaxation. The eyes must be closed to exclude visual stimulation. Extraneous sounds should be at a minimum. The patient should feel at ease and secure but must not be drowsy. We have a sound-proof, light-proof and electrically shielded room with adequate ventilation in which the patient lies on a hospital bed. All amplifying and recording units are operated outside of this room. It is often necessary to leave the door to this room ajar in order to assure a feeling of safety to our younger patients. In this case the eyes are kept closed. In some badly disturbed cases it is necessary to have an observer in the room.

In a state of quiet repose a record obtained from a pair of electrodes, one on the occiput and one on the ear, is dominated by a wave of 10 cycles per second in most normal individuals. These waves are usually found in trains or groups; the average voltage of these waves varying from 20 to 100 microvolts. The interruptions in the rhythm that result in the groupings are relatively frequent, may be rhythmical and may last for long or short periods depending upon some characteristic of the individual at present unknown. This 10 per second rhythm is the alpha or Berger rhythm (alpha rhythm preferred). The frequency in different subjects normally varies from eight to 13 cycles per second but the frequency is surprisingly constant in any one subject from day to day (Loomis, Harvey and Hobart;[33] Travis and Gottlober[36]). The extent of the alpha rhythm has been expressed by Davis[12] as a percentage. This is obtained by dividing the total number of alpha waves possible in at least one-half minute of record by the actual number of alpha waves recorded during that period. The only alpha waves counted are seven microvolts or more in amplitude and in groups of three or more waves. This percentage of alpha rhythm varies from less than 10 to more than 90 in normal subjects.

There is a characteristic localization of this alpha rhythm to a band roughly two inches broad across the occiput of the head above the inion and extending laterally for two inches to either side of the midline. As the active electrode is moved away from this band the amplitude and the percentage of the alpha rhythm generally decreases (Adrian and Yamigima[3]). However, alpha waves can be recorded from any point on the surface of the scalp indicating that all parts of the cortex can function similarly to produce 10 per second waves (Jasper and Andrews[27]).

To complicate matters, other waves of different frequencies are also present although they do not dominate the record unless there is a low percentage of alpha rhythm. When alpha waves are present these other frequencies are superimposed. One of these frequency bands has been designated as "beta" waves and has an average frequency of 26 cycles per second with a range of 20 to 50 cycles per second (Berger[4]). Their voltage is usually 10 to 20 microvolts. Recently Grass and Gibbs[22]

have called attention to another frequency of 18 per second which is normally present but which cannot be evaluated with present data. Figure 1 illustrates typical records from occiput and vertex leads.

Many investigators have offered proof that these potentials are from the cerebral cortex. Records taken with leads on the skull, on the dura and on the pia of a human at operation are changed only in amplitude. These facts indicate that these structures act only as a shunt or short-circuiting system when records are taken from the scalp (Foerster and Altenburger[18]). These structures, therefore, do not appreciably distort the pattern. No smooth frequency in the neighborhood of 10 per second with 20 to 100 microvolt magnitude has been encountered in the white matter of the nervous systems of either experimental animals or humans (Berger[6]). The human electrencephalogram shows no relation to the electrocardiogram, respiration or normal variations of the peripheral circulation (Berger[4]). To make even more conclusive the cortical origin of these phenomena, Kornmüller[28] brought forth evidence that in animals the potential pattern varies with the cyto-architectonics of the cortex under the active lead. We can only conclude from these and many other experiments that the site of origin of the electrencephalogram is the grey matter of the brain.

Action potentials from the skeletal muscles of the head and face can be found in the electrencephalogram but they are sharply differentiated by a spiky appearance, irregular frequency and a very short wave length (Adrian and Matthews[2]). With care these artefacts as well as those which arise from the movement of the head and eyelids can be abolished even during a convulsion.

Perhaps the most striking effect upon the alpha rhythm in normal individuals is the marked depression of amplitude that occurs with visual stimulation (Berger,[5] Fig. 1). In most subjects opening the eyes even in dim light causes almost complete suppression of the alpha rhythm. The rhythm returns, however, as soon as the eyes are closed or may gradually return with the eyes open during the next 15 to 20 minutes. The latter process is facilitated by a visual field that has no pattern and is evenly illuminated. A complex mathematical problem, during its solution, will also suppress the alpha rhythm. In fact, Berger[7] has suggested a close correlation of the suppression of the alpha rhythm with the focusing of attention rather than with any special type of stimulus. Davis, Davis and Thompson[14] and Hoagland[26] have implied in their writings that an emotional factor in each stimulus may also play a part in suppressing the alpha rhythm.

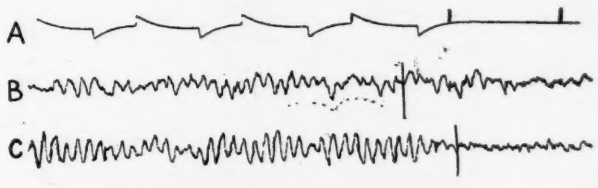

Fig. 1.: E.E.G., No. 41, normal.

Record A: 20 microvolt calibration signal. Negativity of active electrode on scalp relative to the ear lead produces an upward deflection. One second interval between the two vertical marks. Read from left to right.

Record B: Active electrode on left vertex and indifferent electrode on left ear. Normal person. Note the presence of a high percentage of alpha waves with beta waves superimposed. The vertical line is at the approximate time a command was given to open eyes. The flattened record at the right hand end of the tracing is typical of the suppression of the alpha rhythm by visual stimulation. The latency in these records of this suppression is entirely dependent upon the reaction time of the experimenter and the subject and is therefore extremely unreliable.

Record C: Active electrode on left occiput and indifferent lead on left ear. Same subject as in B. Note the higher voltage of the alpha rhythm, its modulated amplitude and the more striking suppression of the alpha rhythm with opening of the eyes after the signal. The same errors in the signal apply as in record B.

The records are from a young woman who has a rather nervous temperament and who has a long standing duodenal ulcer. The nervousness is reflected in the brain waves by some of the occasional slow waves seen from the vertex lead (record B). They are indicated by the faint dots under the record. There was no question of drowsiness at the time of these records.

According to Berger[8] there are no alpha waves at birth. In addition, Berger,[8] Lindsley[32] and Smith[35] have described the presence of slow irregular waves of four per second in infants and the development of more rapid and regular waves (seven to eight per second) with advancing years until at the age of ten to twelve the alpha rhythm of the adult state is obtained.

At present the most acceptable explanation for the origin of the alpha rhythm is that groups of nerve cells in the grey matter of the cerebral cortex change their voltage in unison relative to some neutral point such as the lobe of the ear. Presumably

some pacemaker, as in the heart, keeps the activity of the group of cells synchronized. When disturbed by a pattern of afferent stimulation then the degree of synchronization is markedly lessened. This is exemplified by the suppression of the alpha rhythm when the eyes are opened or when solving a problem (Adrian,[1,2] Hoagland[23]).

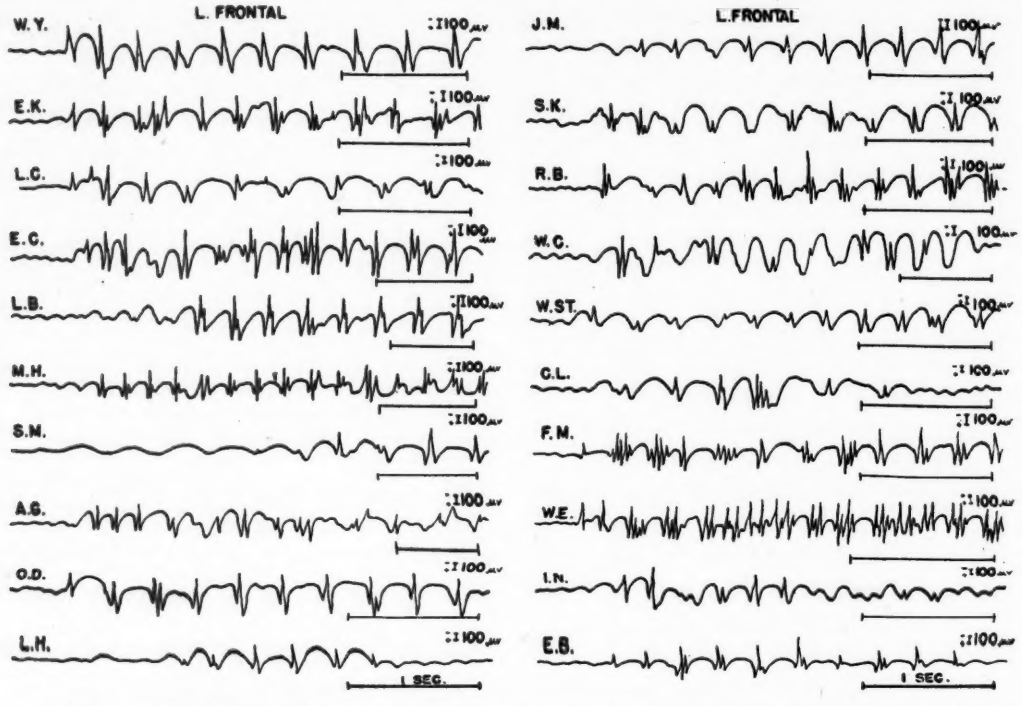

Fig. 2.: Re-photographed from Figure 1, in article of Gibbs, et al, 1936. The following is their legend to this figure:

"Seizure patterns from twenty patients with petit mal epilepsy. All the records show the activity of the left frontal area. Wave and spike formations are obvious in all cases. The duration of the wave and spike formation tends to be about one-third of a second, though it is faster at the start of the seizure and slower at the end. The relatively flat tracing at the left of each record is the patient's normal record. These records were made with one lead to the lobe of the ear and the other to the area designated, the electrode to the ear being connected to the ground of a capacity-coupled amplifier and the other to the grid. The recording instrument was in each case an ink-writing galvanometer. In all records an upward deflection indicates that the electrode connected to the grid was negative with respect to the ear. The calibration in microvolts is given at the end of the record. The horizontal line in the lower right corner marks the duration of one second."

We introduce our description of the changes wrought in the electrencephalogram by pathology with a discussion of the effects of sleep. The pattern of the brain waves during sleep bridges the gap between a normal and an abnormal record. At the onset of sleepiness the alpha rhythm increases in percentage in all subjects until a well established rhythm is present. Shortly after this the alpha waves are broken by pauses of a second or more. At the end of these intervals normal subjects will signal that they have experienced a sensation of "floating." These pauses increase in length and the alpha waves decrease in voltage. A new wave appears at a frequency of two to four per second (Loomis, et al;[3,4] Blake and Gerard;[9] Davis, et al[13,14]). The alpha waves finally disappear and two to four per second waves with spindles of twelve to fourteen per second waves superimposed take the place of the normal record. This pattern is replaced in deep sleep by irregular waves of one to three per second.

Anoxia, on the other hand, while it produces changes that are similar to those of sleep, can be distinguished by the brain wave pattern. Anoxia shows even more clearly the patterns of abnormal activity of the brain. Breathing eight per cent oxygen mixtures produces a slowing of the alpha rhythm to six to eight per second along with the appearance of the slow two to four per second waves. Continuation of anoxia results in the loss of the alpha waves and finally a complete flattening of even the slow waves, at which time the subject's con-

dition is critical. In both sleep and anoxia the presence of slow waves is coincident with a marked impairment of consciousness (Davis, et al[13,14]). We may, therefore, conclude that states of depression leading to unconsciousness are associated with the waves of slower frequency (Gibbs[19]). This is checked by the experiments on brain waves with many anesthetics (Adrian and Matthews;[1] Derbyshire;[16] Lennox[31]). Insulin shock also produces many of these very slow one to four per second waves (Hoagland[24,25]).

The electrencephalogram has been clinically useful in two particular conditions since its development in 1929. The first of these is epilepsy. Gibbs and his collaborators have described three types of brain waves associated with different types of epileptiform discharges (Gibbs, et al[19,20,21]). The following two examples are well known clinically. In grand mal attacks there is a high voltage beta wave recordable over the entire surface of the scalp. This discharge is very similar to that produced in animals by convulsants such as strychnine (Dusser de Barenne[17]). Petit mal attacks on the other hand are associated with a combination of beta and slow waves. These patterns are almost individually characteristic in their exact makeup but they all follow the general plan illustrated in Figure 2 of a slow wave with a spike that has the frequency of a beta wave superimposed. These facts are hardly as practical a point, however, as the observation that slow waves may appear in groups during the record of these petit mal epileptics between seizures. These periods indicate the presence of larval seizures which are not accompanied by any clinical or subjective manifestation. These larval seizures also allow localization by the electrencephalogram of the origin of the epileptiform discharges while the patient is quiet. It is common to find these peculiar larval seizure waves originating in only one area of the cortex and spreading generally through the cerebrum only at the time of convulsion.

The second clinical use of the electrencephalogram which is being rapidly developed is the localization of many forms of cerebral lesions. Walter[37,38] particularly has advanced this phase of the work. He described the localization of tumors by finding a localized focus of slow waves which he called "delta" waves with a frequency of one to four per second (Fig. 3). The electrencephalogram will, however, only show localization of a delta focus after any high intracranial pressure that was present has been removed. Walter[38] has clearly indicated that high intracranial pressure in itself will produce delta waves detectable from the entire scalp. Forster and Altenberger[18] state that the center of a tumor is less active than the surrounding areas and that presumably the delta waves arise from the depressed tissue immediately surrounding the tumor. Recently the signs in the electrencephalogram of cerebral lesions have been added to by Case and Bucy[11] to include: (1) regular delta waves, one-half to three per second; (2) very slow waves from one to two in five seconds; (3) sharp sudden spikes, particularly in groups; (4) patterns characteristic of convulsive seizures, and (5) loss of alpha rhythm on one side. Besides these, Lemere and Yeager and Bolles[39] include: (1) the presence of a strong alpha rhythm that is not affected by visual stimulation; (2) differences in amplitude of the alpha rhythm on the two sides. At present the complete data are insufficient for a description of the brain wave pattern as related to the position or type of the lesion in the cranial cavity. It is apparent, however, that precise localization is possible in many cases by means of this apparatus. We may, therefore, expect future development to allow electrencephalography to take its place alongside of pneumencephalography for the localization of intracranial lesions. The advantages of

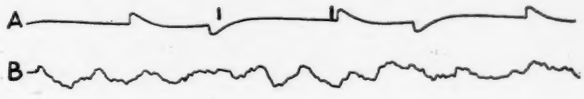

Fig. 3.: E.E.G., No. 7-A:

Typical slow or delta waves from an area near a brain tumor.

Record A: Calibration of 50 microvolts with a filter in the circuit which cuts down the amplitude of all frequencies faster than 30 per second. This produces the rounded tops on the calibration deflections. Negativity of the active lead on the scalp is downward in the record. Read from left to right. The vertical marks indicate a one second interval.

Record B: Record from an 11-year-old patient with a very large cerebral tumor proven at operation. Active lead on the right vertex with indifferent electrode on the right ear. The most obvious phenomenon is the delta wave at a frequency of two to three per second. These waves indicate a depression of cortical function in this area.

electrencephalography over pneumencephalography lie in the complete lack of pain and of danger in the former procedure (Bohn[10]).

Since January, 1938, the authors have been working at Harper Hospital taking electrencephalograms on available interesting cases. We do not have enough cases of any one kind to publish at the present time but we have found many records to be valuable clinically in differentiating and localizing many cerebral disorders.

It would be unfair in a discussion of the field of brain waves to disregard mentioning the interesting but dangerous ground of mental aberrations. Although no correlation of the alpha waves with intelligence can be established (Kreezer[29]) it does appear that confused mental states may readily show up on the electrencephalogram. Hoagland[24,25] has seen the coming events of the schizophrenic patient forecast by the electrencephalogram. Davis has presented suggestive evidence relating personal characteristics with the percentage of alpha rhythm in the state of repose (Davis, et al;[13] Davis[15]).

The electrencephalogram is, therefore, an objective record of the electrical energy manifested by cortical function. Surely this record with its abnormal variations may become as important to the neurologist and clinician as the electrocardiogram has been to the cardiologist.

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NEWER STUDIES AND EXPERIENCES WITH LATEX PROTECTIVE RUBBER SURGICAL DRESSING

DAYTON H. O'DONNELL, M.D.
DETROIT, MICHIGAN

The milky juice as it is obtained from various tropical plans is commonly called latex, commercially preserved by the addition of ammonia. To produce a product adaptable for a surgical dressing the latex is treated with accelerators and anti-oxidants which are colloids, and then allowed to cure in air. The result is a transparent, translucent, waterproof, airtight, adhesive, sterile protective coating. Latex is a carbohydrate. Its chemical structure is not yet definitely known, but we do know that artificial rubber can be manufactured from Iosprene (C5H8) by polymerization.

Effects on Healing

Dr. Maurice Brodie, associate pathologist at Providence Hospital, and the author undertook about one year ago to make skin incisions on the backs of rabbits. Fourteen animals were incised for a distance of 2 cms. on each side of the spine at level of the middle third. One incision had latex compound applied directly to the line of incision; on the opposite a standard gauze dressing was applied for control. The incision with the rubber protective coating was excised in ten, twenty-three, and forty-eight hours, and every day thereafter for thirteen days, together with the control incisions, for microscopic studies for the appearance of fibroblasts, fibrocytes, capillary buds and round cell infiltration. Our experimental results were in accord with the findings of Leon S. Smelo[7] as outlined: "Through a method of qualitative evaluation of the effect of local agents on the velocity of wound repair, it has been demonstrated that the substances tested including antiseptics, stimulants, and inert material failed to affect significantly the processes of repair. Factors other than local dressing appear to plav a dominant rôle in determining the rate of wound healing."

In our experiments the fibroblasts, fibrocytes, and capillaries made their appearance at about the same time in both the control and the incision with the rubber protective coating.

Predisposition to Infection

In none of our animals did the control and the questioned incision show any changes in the different cellular infiltrations. We applied the protective rubber surgical dressing on most of our dry, clean surgical cases since September, 1935, since which time, we have had only one incisional abscess. This was a case that two weeks after onset of drainage an undigested piece of chromic catgut about 2 cm. long was removed from the draining sinus; this was followed by immediate repair. Altogether the material was applied to over two hundred clean surgical cases. Dr. Brodie has examined the material bacteriologically and has found it sterile, even after being tubed one year. It has a phenol coefficient of less than one and is mildly antiseptic.

Irritating Factors

It is generally known that ready-made rubber goods such as rubber gloves, may give rise to eczema. The only case reported (Niles[4]) prior to 1933 is that of dermatitis due to a rubber bunion protector. Downing[1] and Halloran[2] have reported cases since that time. M. E. Obermayer[5], in his studies and experiments on eczema due to hypersensitiveness to rubber, states, "As one can see, a great variety of chemicals are employed in the manufacturing of rubber products. Hence, the reports from physicians taking care of the health of men working with rubber contains a vast number of cases of dermatitis due to external irritants. Dr. P. A. Davis of the Goodyear Rubber Co. who is chairman of the section on Preventive and Industrial Medicine and Public Health of the A.M.A., published a series of articles on the toxicity of substances that were known to produce dermatitis have since been eliminated from the rubber industry in this country wherever possible." Schwartz and Louis Tulipan[6] describe eight workers affected with dermatitis following the introduction of accelerators and anti-oxidants for the first time in a rubber plant. A comprehensive classification of the materials

used in the rubber industry and their hazards to health was recently published by the National Safety Council. In many instances it is not the chemical substance itself but impurities which the commercial product contains that give rise to dermatitis. In the majority of cases the dermatitis was due to one of the accelerators.

The protective rubber surgical dressing the author has developed did not cause a single case of dermatitis or irritation except in a few cases where plain catgut was used and came in contact with the surface of the skin and the rubber dressing. This reaction was in the form of a burn; however, we could not produce these results in rabbits. Since we have ceased using catgut for a skin closure, excepting subcuticular we have not seen this, which was the only complication in two and one-half years of clinical trial.

Comfort of the Patient

We have had many cases of bilateral herniorrhaphy. On one side we applied the ordinary standard dry or vaseline gauze; on the other side, the rubber surgical dressing. Invariably, within four days the patient requested the standard or vaseline gauze be removed and the protective rubber surgical dressing be applied. The rubber dressing has been used in several thyroidectomies and the usual soreness of the neck and throat was found to be greatly minimized; so much so, that morphia or other narcotics were withdrawn after twenty-four hours in the majority of cases. The indications for the use of the protective rubber surgical dressing are:

1. All clean, completely closed surgical wounds, where closure has been with any material other than catgut.

2. Preoperative protective coating of the entire abdomen where pre-existing pustules or acne, or dermatitis exists which is dangerous to the aseptic progress of the case. This rubber surgical dressing after it has been air-cured, may be painted with a germicide such as tincture of iodine, and the incision made directly through it.

3. In cases of planned fistula, according to Strauss[8] the skin may be protected against the excretions or secretions, by protecting the healthy skin by a layer of rubber dressing just previous to the making of the fistula. Where the fistulæ exist, coating of the affected skin; the dressing will protect the skin for two to three days under conditions of emersion. The same procedure may be adopted in all cases of anticipated drainage when the drained material may be irritating to the skin.

4. The dressing is especially useful in surgery in infants where the urine and stool may contaminate the wound.

5. As suggested by Frederick Weymann Morie,[3] for holding gauze in place, as eye pads, et cetera the technic of applying the dressing is simple. The most important consideration is that the surface to which it is to be applied be dry. Therefore, we have made it a practice of applying a dry gauze dressing to the incision for twenty-four hours, then removing and applying a thin coat of the rubber surgical dressing directly to the line of suture and about 2 cms. of the surrounding area. A sterile cotton applicator is used to spread and even up the edges. Drying may be accelerated by using an ordinary hair dryer to drive out the aqueous material. Ordinarily, this takes from two to seven minutes, depending upon the thickness of the dressing applied. When the latex compound is applied it resembles milk, but in a few minutes it becomes shiny, transparent, translucent, air-tight and waterproof, and an adherent protective coating. At this time, a coat of ordinary talcum powder, or when indicated, sterile powder should be applied.

The advantages of the rubber surgical dressing are:

(a) It is economical, as after the first application, it is ordinarily not necessary to reapply it.

(b) The patient complains of less pain.

(c) The incision and progress of healing may be observed without changing the dressings and interfering with healing. Where a subcuticular silkworm suture is used with one end buried free, and the other end held by a lead ball fixed flush with the skin, the lead ball is freed from the rubber and withdrawn with the suture without removing the dressing.

Summary

1. Latex compound is a sterile, shiny, transparent, translucent, air-tight, waterproof, adherent, protective surgical coating.

2. Indicated as a subsequent dressing in dry, clean surgical incisions, especially in

children and infants, as a protection against fecal and urine contamination.

3. As a primary protection of healthy skin in anticipated fistulæ or drainage, and as a primary coating to the entire operative area with the underlying skin and the overlying rubber dressing sterilized with the application of a germicide, and the skin incision made directly through the rubber surgical dressing.

4. Bacteriologically, the material is sterile and pathologically it has no influence on the velocity of healing or irritation to the skin.

5. Advantages of affording ease of observation of progress; the removal of a subcuticular suture without removing the dressing, the splinting of the edges of the incision, reducing the incidence of pain and the economy of a single permanent dressing.

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TEN YEARS OF TREATMENT AND PROGRESS IN A CASE OF CHRONIC MYELOID LEUKEMIA

The Lipid Distribution in Leukocytes and Erythrocytes

MARSH W. POOLE, M.D., BETTY N. ERICKSON, M.S., and HAROLD H. WILLIAMS, Ph.D.

The Research Laboratory of the Children's Fund of Michigan, Detroit, Michigan

H. J. BURKHOLDER, M.D., Alpena, Michigan

T. LEUCUTIA, M.D., Harper Hospital, Detroit, Michigan

In spite of the attention that has been directed toward the study and treatment of myeloid leukemia since its original description by Bennett and by Virchow, in 1845, there still remains a great deal of progress to be made in the control of this malignant disease. One of the striking things about myeloid leukemia is the extreme variation that occurs in the duration of the illness. The acute form completes its course in only a month or two, while the chronic types have been known to last as long as ten years.[3] The average expectancy is about three and a half years.

It is seldom possible to follow these cases over the entire span of the disease's activity. This report details a case of chronic myeloid leukemia through a period of over nine years, from onset to October, 1937. This complete and accurate résumé was made possible by the intelligent coöperation and intense interest of the patient, Mr. Burnett Green, of Alpena, Michigan. During these years he has maintained a case history, recorded all of his blood counts, completed a curve representing white cell levels throughout the course, and made all of his own leukocyte counts except when hospitalized.

The patient, Mr. Green, is white and at the time of the onset of the disease was thirty years of age (1929). There was no history of abnormal blood conditions in the family. He had had an appendectomy in 1914, following an acute attack of appendicitis. Tonsils were removed in 1923. There was no history of chronic or focal infection.

The onset of the disease was typically insidious. For a year previous to his initial examination he suffered intermittent excruciating pain across the lower back, brought on by excitement or sudden exertion. At these times he was obliged to sit down to recover from dizziness and a sensation of "everything going black."

Examination by his family physician in January, 1930, revealed no physical abnormalities other than the spleen being palpated two finger breadths below the costal margin. At that time the total leukocyte count was 27,000.

Upon admission to Johns Hopkins Hospital for examination January 23, 1930, it was found that the spleen had increased tremendously in size and at that time extended down into the pelvis and across

the midline into the right side of the abdomen. The total leukocyte count had risen to 750,000. A diagnosis was made of severe myeloid leukemia which appeared from the blood picture to be of a subacute type. X-ray treatment was advised.

The x-ray treatment was carried out at the University of Chicago Clinics, Billing's Hospital, by the Department of Roentgenology under the supervision of Dr. Russel M. Wilder of the Department of Medicine. During the period from January 26 to February 12 the patient received ten x-ray exposures. The exposures were given over the following areas: Left ribs and humerus, right ilium (anterior), left ilium (anterior), lower spleen (anterior and posterior), upper spleen (anterior and posterior), lateral spleen (upper and lower). The technique used was: 200 kv., 25 ma., 6 min., 150 mam., 50 cm. std., .5 cu, 1 al, 20 cm. or 15 cm. in diam. fields. During this period the leukocyte count fell to 167,000 and the basal metabolic rate from +43 to +9. Improvement continued slowly after his return home.

During a second admission, from April 9, 1931, to April 31, 1931, a second series of x-ray treatments were given, with about the same dosage, over three fields, spleen (anterior), left thorax and humerus (anterior), right thorax and humerus (anterior). The leukocyte count at this time was 55,900.

A third period of hospital treatment extended from May 8, 1931, to May 13, 1931. Blood count showed 73,000 white blood cells with myelocytes 10 per cent, metamyelocytes 25 per cent, polynuclear cells 55 per cent, small lymphocytes 6 per cent, eosinophiles 3 per cent. Using the same factors eight exposures were used over the following areas: Anterior lower right femur, anterior upper right femur, anterior lower left femur, anterior upper left femur, posterior right pelvis, posterior left pelvis, posterior upper tibia, posterior thoracic spine.

This third series of treatments was followed by cycles of medication with Fowler's solution. It was taken for twenty-one days, starting with 5 drops t.i.d. and increasing 1 drop t.i.d. until 9 drops were being used t.i.d. This was followed by a three week rest period.

A fourth series of x-ray treatments was given during the summer of 1932 using three or four individual areas. Fowler's solution was continued.

During the fifth series of x-ray treatments in September, 1933, the dosage was increased because of the lessened effect of the roentgen rays.

Repeated leukocyte counts by the patient varied from 4,000 to 40,000 until the latter part of 1934 when the total rose to 100,000 and repeated Fowler's solution seemed ineffectual in reducing it. The Department of Roentgenology at Harper Hospital, Detroit, instituted deep x-ray therapy on January 12, 1935. At that time the patient was described as tall, quite under-nourished, weight 130 pounds, the skin somewhat bluish as if he were having slight dyspnea. The general condition, however, was quite satisfactory. The spleen was moderately enlarged, being five finger breadths below the costal margin. There was no adenopathy. Hemoglobin 10.5 grams, red blood cells 4,200,000.

On October 26, 1936, the total leukocyte count was 162,000. The differential count—myeloblasts one per cent, myelocytes 13 per cent, nonsegmented polys 65 per cent, segmented polys 19 per cent, and lymphocytes 2 per cent.

The Research Laboratory of the Children's Fund of Michigan made chemical determinations of the lipid distribution in the blood of this patient. While these determinations are available for only one case, the

TABLE I. DEEP X-RAY THERAPY TREATMENTS

Treatment No.	Date	Area	Constant Factors-Cone 1, 200 kv. 1½ mm. cu., 1 mm. al., 20 ma., 50 cm. std. Dosage
	1935		
1	Jan. 12	Spleen directly	6 min., 120 mam., 20 r.p.m.
2	Jan. 19	Spleen directly	6 min., 120 mam., 20 r.p.m.
3	Feb. 2	Spleen directly	6 min., 120 mam., 20 r.p.m.
4	Feb. 9	Spleen directly	6 min., 120 mam., 20 r.p.m.
5	Feb. 22	Spleen directly	6 min., 120 mam., 20 r.p.m.
6	Mar. 9	Spleen directly	6 min., 120 mam., 20 r.p.m.
7	Apr. 3	Spleen directly	6 min., 120 mam., 20 r.p.m.
8	Apr. 27	Spleen directly	8 min., 160 mam., 20 r.p.m.
9	May 11	Spleen directly	8 min., 160 mam., 20 r.p.m.
10	June 15	Spleen directly	8 min., 160 mam., 20 r.p.m.
11	July 5	Spleen directly	6 min., 120 mam., 20 r.p.m.
12	July 16	Spleen directly	6 min., 120 mam., 20 r.p.m.
		Both tibia (ant.)	10 min., 200 mam., 20 r.p.m.
13	Aug. 3	Spleen directly	6 min., 120 mam., 20 r.p.m.
		Both lower and upper legs (ant.)	8 min., 160 mam., 20 r.p.m.
14	Sept. 4	Spleen directly	6 min., 120 mam., 20 r.p.m.
		Lower thighs (ant.)	8 min., 160 mam., 20 r.p.m.
15	Dec. 16 1936	Spleen directly	6 min., 120 mam., 20 r.p.m.
16	Jan. 3	Spleen directly	6 min., 120 mam., 20 r.p.m.
17	Jan. 20	Spleen directly	6 min., 120 mam., 20 r.p.m.
18	Mar. 5	Spleen directly	6 min., 120 mam., 20 r.p.m.
19	May 30	Spleen directly	6 min., 120 mam., 20 r.p.m.
20	June 15	Spleen directly	6 min., 120 mam., 20 r.p.m.
21	June 26	Spleen directly	6 min., 120 mam., 20 r.p.m.
22	Oct. 3	Spleen directly	6 min., 120 mam., 20 r.p.m.
23	Oct. 16	Spleen directly	8 min., 160 mam., 20 r.p.m.
24	Oct. 24	Spleen (posteriorly)	10 min., 200 mam., 20 r.p.m.
	Oct. 25	Spleen (posteriorly)	10 min., 200 mam., 20 r.p.m.
	Oct. 26	Spleen (ant.)	10 min., 200 mam., 20 r.p.m.
	Oct. 27	Spleen (posteriorly)	10 min., 200 mam., 20 r.p.m.
25	Dec. 12 1937	Spleen directly	10 min., 200 mam., 20 r.p.m.
26	Jan. 6	Spleen (ant.)	10 min., 200 mam., 20 r.p.m.
27	May 1	Spleen (laterally)	8 min., 160 mam., 20 r.p.m.
28	May 19	Spleen (laterally)	6 min., 120 mam., 20 r.p.m.
29	June 5	Spleen (laterally)	6 min., 120 mam., 20 r.p.m.
30	July 27	Spleen (ant.)	7 min., 140 mam., 20 r.p.m.
31	Aug. 26	Spleen (ant.)	7 min., 140 mam., 20 r.p.m.
32	Sep. 13	Spleen (ant.)	10 min., 200 mam., 20 r.p.m.
		Spleen (laterally)	10 min., 200 mam., 20 r.p.m.
33	Oct. 2	Spleen directly	6 min., 120 mam., 20 r.p.m.

duration of the case, together with the completeness of the records kept by the patient, makes the data valuable.

The lipid composition of the plasma, red blood cells and the white cells was determined by the gasometric technic of Kirk, Page and Van Slyke.[4] In addition, the minerals (sodium, potassium, and chloride) were determined in the serum and the erythrocytes by standard methods.[5]

The serum minerals were found to be normal. The plasma lipids, however, were increased above normal values and indicated a slight lipemia. Separation of the plasma lipids into the various lipid fractions revealed that the phospholipid and free cholesterol components were within the normal range. The neutral fat fraction was high and the cholesterol esters strikingly low. Normally the fatty acid esters of cholesterol constitute the greater portion of the plasma lipids and the neutral fat fraction accounts for only a small part of the total fat. In the present case there appears to be a derangement in fat metabolism resulting in deficient cholesterol ester synthesis.

The red blood cells were normal in their chemical composition, with respect to the lipid components, but the mineral content was abnormal, having elevated levels of sodium and chloride.

The lipid analysis of the white cells revealed a low lipid content as compared to the normal values determined by Boyd.[1] The two are not strictly comparable, however, since he used a different method. Boyd and Stephens[2] have shown that the phospholipid and free cholesterol content, which compose 80 to 90 per cent of the total fat of the white cell, varies roughly in proportion to the percentage of neutrophils present. Comparison of the lipid composition of the white blood cells in the present case with those of Boyd,[1] who has so far published the most complete analysis of the leukocytes in leukemia, shows that the findings in this case resemble those he found in chronic lymphatic leukemia.

Table II shows the complete blood analysis in comparison with the normal.

Too great emphasis cannot be placed upon the valuable assistance rendered by this patient in the compilation of this interesting graphic description. The fact that the patient was of superior intelligence and at the time of his affliction was financially able to investigate his condition has been of incalculable benefit. The patient meticulously made white counts and kept a detailed case record throughout. From his charts and compilations the accompanying graph was made showing the stages of the white cell count as coördinated to the treatments being given at various intervals. Fowler's solution was taken four times during 1937, but has been omitted from the chart because the time of treatment was not available. This is due, probably, to the mental burden of the patient being increased by the death of his wife. It is interesting to note that the two highest peaks on the graph occur during periods just after the death of Mr. Green's wives.

Mr. Green, at this time (November, 1937), is still alive and continues his routine x-ray treatment varied or accompanied by Fowler's solution. The fact that this patient has maintained himself for over nine years is probably attributable in great part to his own efforts and studies. He is still able to carry on his normal business activity.

The patient starts to take the solution of potassium arsenite (Fowler's solution) when the leukocyte count rises to 20,000, increases it up to 27 drops daily and maintains the dosage at that level for three to four days if abdominal cramps and enteritis do not become too severe. When the leukocyte count falls slowly, arsenic is continued at a high level for several more days; when it falls rapidly he begins to reduce the dosage when the white count drops to 20,000, and stops it at 10,000. If the white blood cell count rises to 50,000 he plans to have a deep x-ray treatment at Harper Hospital, Detroit, the following weekend. Throughout the entire illness, to avoid becoming resistant to the effect of the rays or tolerant of the effects of arsenic, he has tried not to use potassium arsenite or x-ray exposures over too long a period.

During the time of arsenic administration the skin becomes hyperesthetic, and as the dosage is increased diarrhea develops, with blood in the stools. Epistaxis of short duration is troublesome when the leukocyte count reaches 60,000 to 70,000. During wet weather he complains considerably of the bones aching, particularly the back and hips.

Mr. Green believes that the onset of his illness resulted from chronic overwork, as

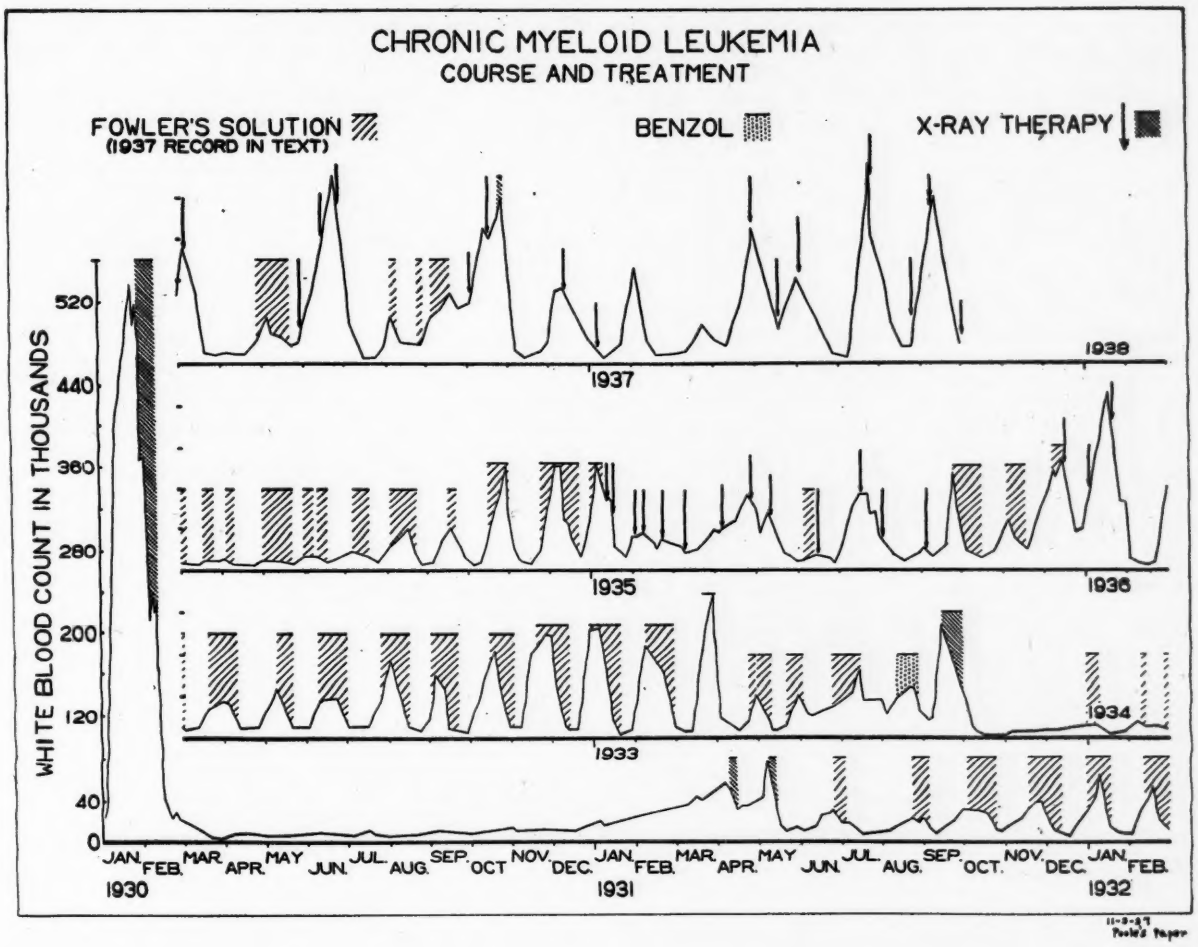
TABLE II. DISTRIBUTION OF LIPIDS IN BLOOD*

Constituent	PLASMA			
	Leukemia		Normal (**)	
	Mg. per 100 cc.	Per Cent of Total Lipid	Mg. per 100 cc.	Per Cent of Total Lipid
Total lipid	946		735	
Phospholipid	213	23	181	25
Neutral fat	477	50	225	31
Total cholesterol	194		232	
Free cholesterol	103	11	82	11
Cholesterol esters	153	16	254	35
	Milli-equivalents per liter			
	Leukemia		Normal (**)	
Sodium	153		140	
Potassium	3.6		4.4	
Chloride	105		103	

Constituent	RED CELLS			
	Leukemia		Normal (**)	
	Mg. per 100 gm.	Per Cent of Total Lipid	Mg. per 100 gm.	Per Cent of Total Lipid
Total Lipid	545		424	
Phospholipid	339	62	244	58
Neutral fat	78	14	51	12
Total cholesterol	124		116	
Free cholesterol	119	22	97	23
Cholesterol esters	8	1	32	7
	Milli-equivalents per liter			
	Leukemia		Normal (**)	
Sodium	27		17	
Potassium	110		104	
Chloride	105		52	

Constituent	WHITE CELLS			
	Leukemia		Normal (**)	
	Mg. per 100 gm.	Per Cent of Total Lipid	Mg. per 100 gm.	Per Cent of Total Lipid
Total lipid	543		1455	
Phospholipid	366	67	869	60
Neutral fat	33	6	209	14
Total cholesterol	130		320	
Free cholesterol	110	20	238	16
Cholesterol esters	34	6	139	10

*July 17, 1935.
**Bibliography reference 6.



well as his mode of living, sleeping irregularly, eating at improper intervals, and traveling a great deal. He also thinks that it bears a close relationship to the emotional shock resulting from the death of his first wife and son in 1928. Calmness and quiet seem to be of value in making it easier to control the white cell level. He relates the rise in the leukocyte count during December, 1935, to the anxiety caused by the serious injury of his wife. During the past summer he has again been subjected to the strain consequent to the death of his second wife.

The white blood cell level seems easier to maintain within reasonable limits during the hot summer weather, when he can get out into the sunshine. Ultra-violet light from artificial sources seems to do harm rather than good. The diet is rich in all the vitamins and high in calories, one-half pint of cream being included in each day's breakfast. Fatigue is still prominent, so that it is necessary for him to sleep twelve hours or more each night. In order to do this he has had to change his occupation and has been able to found a new business during his period of illness. In 1930, he was told he had only a year to live. He has maintained himself over nine years, and while continuing to seek a means of cheating the reaper indefinitely his attitude is cheerful, as he feels he has already lived eight years on "borrowed time."

Since this paper was submitted, late in 1937, the death of Mr. Green has concluded one of the longest and most complete case records of chronic myeloid leukemia. Mr. Green died at Harper Hospital, Detroit, February 4, 1938. For the period from October, 1937, to the time of his death, the following data have been procured through the coöperation of Dr. George Leckie and Dr. Hazen Price, of the Harper Hospital staff. The pathological report is available through the courtesy of Dr. Plinn Morse.

The patient was admitted to Harper Hospital January 1, 1938, with pain in upper left quadrant of abdomen. Pus had been found in urine and temperature had ranged from 100-103°. Loss of appetite and weight. Appeared moderately ill, emaciated, several carious teeth, few râles in bases of both lungs, no

friction rubs, prominent cardiac impulse, marked venous pulsation in neck. Blood pressure: systolic 120, diastolic 45—systolic murmur of blowing type in pulmonic area. Right border of cardiac dullness 3 cm. to right of midsternal line. Abdomen somewhat distended. Tender on left side. Firm mass left on left side extending down to below the umbilicus. Skin dry and discolored. Temperature range while in hospital from 100° to 105°.

Films of hands, pelvis, upper thighs and lumbosacral spine: No changes evident on bone structures of hands, lumbosacral spine or pelvis. In upper portion of right femoral shaft just beneath intertrochanteric line there was a very definite area of increased radiability with a somewhat motheaten appearance of the bone. This had not given rise to any expansion of the cortex and there was no evidence of frank destruction and periosteal reaction. There were also several places in the shafts of both femora showing evidence of a destructive process.

Upon admission to the hospital the W.B.C. was only 18,000, notwithstanding the immense size of the spleen. The hemoglobin was 43 per cent and R.B.C. 2,740,000. Juv. polys 49, segm. polys 32, lymphocytes 19. Hypochromia, aniso- and poikilocytosis. Daily white counts from January 26 to February 4 (time of death) were: 16,700; 25,400; 21,900; 27,900; 44,400; 78,900; 107,100; 135,000; 117,100; and 125,000. During this period two series of deep therapy x-ray treatments were given.

Blood chemistry January 27, 1938:

Reticulocytes, 0.5%
Color index, 0.81
Erythrocytes, 2,680,000 (mean diam. 7.28μ)
Occasional megaloblasts and normoblasts
Thrombocytes 525,000, hemoglobin 43%
Coagulation time, 2 minutes
Leukocytes, 20,650

Promyelocytes, 7%		
Myelocytes—Basophilic		3%
	Eosinophilic	3%
	Neutrophilic	25%
Metamyelocytes		3%
Neutrophils, stab.		6%
segm.		3%
Eosinophils		4%
Basophils		18%
Lymphocytes		7%
Plasma		1%
Monocytes		17%

Capillary fragility negative; several monocytes present which have some of the characteristics of myeloid tissue: marked basophil aggregation.

Blood chemistry January 30, 1938:

Sugar	0.126	Urea N	16.2
Creatinine	2.1	Phosphorus	4.2 mg.
Phosphatase	9.7	N.P.N.	66.6 mg.

Urine on five occasions showed many granular casts, a few W.B.C.'s and traces of albumin and acetone. January 29—Pleural rub in left lower chest; January 30—blood transfusion, 100 c.c. January 31—pleural rub left chest. February 2—Evidence of bronchopneumonia in left lower chest, temperature high, pulse rapid—more toxic. February 4—died.

Autopsy report, February 5, showed:

Body emaciated, no purpuric spots or petechial hemorrhages in the skin. Abdomen scaphoid. Firm, smooth mass in left upper quadrant extended to the level of the umbilicus. Lower border of the liver 4 cm. below right costal margin. Generalized shotty adenopathy. External examination otherwise negative.

Usual incision showed panniculus orange yellow and 1 cm. thick. Lower border of the spleen at the umbilicus. Spleen weighed 2,120 gm. and was a mottled purple. White spots varying in size from 0.5 to 1 cm. in diameter throughout the spleen. Spleen was firm and the splenic pulp did not scrape away easily. Intestinal tract, bile passages, kidney and adrenals negative. Liver was somewhat mottled, yellowish light brown color, capsule smooth and shiny, weight 2850 gm. Periaortic lymph nodes were shotty and friable. Right kidney 150 gm., left, 200 gm.

Visceral and parietal pleura on the right side adherent over their whole area. Pericardium negative. Heart grossly negative, weight 400 gm. Right lung was removed with difficulty due to adhesions, weighed 400 gm. and was a mottled grayish color. Left lung weighed 550 gm. and was grossly negative. Other structures of the thorax negative except the lymph glands, which show a shotty lymphadenopathy.

The sixth rib on the left side was removed and presented an invasion into it of a whitish, friable material. Examination of the bone marrow from the sternum showed it to be of a cream color, appearing purulent.

Gross Pathologic Diagnosis: Chronic myeloid leukemia, chronic obliterative pleuritis (right), general atherosclerosis, leukanemia.

Microscopic Diagnosis: Lung—terminal bronchopneumonia with diffuse leukemic infiltration of alveolæ. Heart muscle—negative. Liver—diffuse leukemic infiltration of liver parenchyma. Spleen—leukemic transformation of spleen pulp. Kidney—negative.

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THE EVALUATION OF URINARY SHREDS IN PRENUPTIAL EXAMINATIONS*

GEZA SCHINAGEL, M.D.
DETROIT, MICHIGAN

In connection with the present-day trend toward prenuptial examination for venereal diseases, the medical man is very often confronted with the matter of shreds in the urine.

Shreds consist of leukocytes and epithelial cells enmeshed in mucous or fibrous substances. They might appear after any urethral inflammation—not necessarily only after gonorrhea. Their origin is largely due to epithelial cell metamorphosis of the mucous membrane or glands of the urethra.

The color of shreds changes from gray to yellow-white, the lighter color indicating the increased leukocyte content.

A large number of shreds is always suspicious; a single shred, especially after a longer urinary retention (three to five hours) could be neglected. Macroscopically the light shreds, which usually float in the urine, are due to superficial mucous irritation or congestion, as in a chronic infection, or they might be epithelial filaments, which originate during the restorative (healing) process of inflammation. They are finely curved and two or three are found together.

Large comma-like mucoid shreds indicate a chronic inflammation as prostatitis; small comma-like transparent shreds, which microscopically consist of an epithelial lining, might be derived from a Littre's gland or collicle, or masculine utricle, or from the prostatic duct.

The heavy shreds, which sink to the bottom of the glass, are always mucopurulent and indicate a subacute or acute process.

We find also very long, small, thin, opaque, and sometimes transparent shreds which are derived from the prostate and seminal vesicles.

Sometimes we find 1 to 1.5 cm. long, thin, finely-tortuous shreds in which are enmeshed small vesicle-like transparent globes. They originate in the ejaculatory ducts and consist of leukocytes, mucin, and sometimes spermatozoa.

For microscopic examination we must place a shred on a slide and stain it. The technic is very simple. Pass a platinum loop through the flame and with it fish out one or two filaments and place them on a slide. Or let the shreds sink to the bottom of the urine, remove the superfluous urine and fill it up with distilled water several times, removing thereby the salts in the urine which might disturb one's view. A centrifuge would hasten the process. Fish out the shred, or, if this is difficult, pour the urine in a Petri's dish containing a slide, thereby placing the shred on the slide. Dry off the excess moisture with blotting paper and break up the shred on the slide with a circular movement of the platinum loop over the surface, thereby making as thin a film as possible.

For staining, methylene blue is used. In a slide with shreds, mucin, epithelial cells, leukocytes, and bacteria, which are common in the normal urethra, are generally found. Occasionally there are diplococci, which always indicates Gram staining for the exclusion of any gonococci.

If the smear shows mostly epithelial cells, mucin, and only a few leukocytes, it is not necessary to investigate further, but if the leukocytes are in the majority, one must be on guard, because leukocytes indicate inflammation and inflammation in the urethral mucous membrane is always suspicious of gonorrhea; therefore, a Gram staining several times should be made as well as a culture.

Convinced that there is no gonorrhea present, a search for other sources of an inflammation, because there are patients who never had gonorrheal infection and yet have shreds, should be undertaken. Such sources might be the treatment-resistant, non-venereal urethritis, urethritis after frequent prophylactics, after catheterism, phosphaturia, chronic induration of the urethral mucous membrane, urethral stricture, ulcers, stones, foreign bodies, neoplasm, villi on the bladder sphincter, and on the verumontanum. For clearing up these sources, urethral endoscopy is employed.

*From the Urological Division, City Physician's office, Detroit.

Other sources are peri-urethritis, Cowperitis, when the gland is palpable between the anal ring and the lower border of the prostate, and prostatitis. In the normal prostatic smear occasional leukocytes are present, but if there are one or two present in every view, there is inflammation. This does not necessarily mean gonococcic, as they might be due to masturbation, interrupted intercourses, bicycle or motorcycle riding, or following pneumonia or influenza.

If the shreds do not disappear after treatment, according to the sources mentioned above, we do provocative treatments which consist of maximal dilatation of the urethra several times in one sitting, and injection of a 2 to 5 per cent solution of silver nitrate or pilocarpin solution, 0.5 mille per cent, several times daily (according to Japanese investigators), the consequent discharge and shreds being examined for several days for gonococci.

Summary

1. Shreds in urine should be microscopically examined for nuptial permits.
2. Shreds in urine do not indicate gonorrhea; they point only to an inflammation, the source of which should be satisfactorily explained.
3. The size, shape, and weight of a shred are not satisfactory guides to judge the location or severity of a urethral inflammation.

4400 Livernois.

VISUAL STANDARDS FOR OPERATING MOTOR VEHICLES

Recognizing the increasing necessity for greater care in the operation of motor vehicles on the highways, the House of Delegates of the American Medical Association at the recent San Francisco meeting adopted the following resolution. The standards set forth were developed by the Section on Ophthalmology, where this program had been under consideration for many years:

Resolved, That the following be accepted as the approved American Medical Association standards:

A. For an Unlimited License:
   1. Visual acuity with or without glasses of 20/40 Sn. in one eye and 20/100 Sn. in the other.
   2. A form field of not less than 45 degrees in all meridians from the point of fixation.
   3. The presence of binocular single vision.
   4. Ability to distinguish red, green and yellow.
   5. Night blindness not to be present.
   6. Glasses when required be worn while driving and those employed in public driving and those employed in public transportation be provided with an extra pair.

B. Visual Standards for Limited License:
   1. Visual acuity of not less than 20/65 Sn. in the better eye.
   2. Field vision of not less than 60 degrees horizontally and 50 degrees vertically from point of fixation in one eye.
   3. Diplopia not to be present.
   4. Glasses to be worn when prescribed.
   5. Coördination of eye, mind and muscle to be fully adequate to meet the practical visual road tests.
   6. A limited license not to be issued to those employed in public transportation.

C. Renewals, Retesting and Reëxaminations:
   1. Renewals of license to be issued at least every third year. The applicant shall with each renewal make a declaration that he knows of no visual defect which has developed during the past year.
   2. Retesting of acuity to be made at least every six years.
   3. If any visual defects have developed, an examination by an ophthalmologist and the report thereof, to be required before re-issuing the license.
   4. License to state thereon the specific limitation for driving.

—*Jour. A.M.A.,* Aug. 20, 1938.

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NOVEMBER, 1938

"Every man owes some of his time to the upbuilding of the profession to which he belongs."

—THEODORE ROOSEVELT.

EDITORIAL

CREDIT TO WHOM CREDIT IS DUE

"AND yet, by any measure we can apply through historical comparison or contemporary statistics, we do now appear to be at the very zenith of a period of amazing improvement in health. In fact, never before has any substantial part of our population, nor has at any time recorded history of man, any population of such size, diversity or racial, climatic and social conditions in any other continent or under one government been so relatively free from communicable disease, so likely to have its children survive the hazardous years of infancy and early childhood, or to so nearly approach the Biblical term of years of life.

"If, as the spokesmen and women of the technical committee and interdepartmental board in Washington have recently announced, the facilities for public health are grossly insufficient, it may be well to remind them that it is not by their efforts that we have reached the summit of the foothills of health, and that less extravagance of statement would better become a federal government which now offers little new to us, other than to put our children and grandchildren more deeply into debt for their health, so that it, the present federal administration, may claim merit for doing, suddenly and at great cost, what society and medicine have been achieving slowly, steadily and surely within the means of thrifty communities to pay as they go. True there are mountains of unnecessary disease and human suffering to be tunnelled, scaled, or worn down by the gradual erosion of scientific progress, but human biology can rarely be hurried, even by billions, and it has a way of making its more enduring advances in human survival by evolution rather than by revolutionary variants in social method."—DR. HAVEN EMERSON (see Andrew P. Biddle lecture, leading article this number of THE JOURNAL M.S.M.S.).

DIVIDE ET VICI

THERE is an old saying, possibly Shakespeare said it first, that a rose by any other name would smell as sweet. There has been much adverse discussion in this country of the various political isms, including totalitarianism, a mouthful in itself. No matter what the ism, the effect on the individual is the same, namely, the deprivation of certain liberties which he enjoys under a democracy. We have said this time and again in various forms and it will doubtless be necessary to repeat the idea with variations in the future.

The American people for two or three federal elections past have had the question, Do you want socialism? put to them in the form of a socialist candidate for president. The answer by and large has been most emphatically, No! and yet it would appear that the very thing which the American people in mass turn down, they are willing

to swallow if given to them piecemeal. There is an old Latin saying, "divide and conquer," which carries with it a moral. Any task which appears to be huge in its totality may be accomplished by dividing and attempting a little at a time. Probably the single outstanding attribute of totalitarianism, which by the way includes all the isms so far as political philosophy is concerned, is the centralization of power, till in the last analysis, it is centralized in the so-called strong man.

It is almost unnecessary to mention that in this JOURNAL there is no attempt to discuss party politics, so that when we speak of limitation of federal power, or decentralization of power, we do not have in mind either a democratic or republican government. "The heady wine of power" is bad wherever we find it. We advocate as much liberty for the individual as is consistent with the liberties of all other individuals; also liberties for groups so long as this freedom does not interfere with the rights of other groups.

Now then. In the offing is the Welfare Organization Bill in this state, a measure devised for the purpose of promoting more efficient public welfare in a number of directions. Let us give the proponents of the measure credit for good intentions. Yet this measure in the last analysis tends to hand over the rights and prerogatives of certain groups together with anything that may be demanded in the future, in the way of amendments or supplements, for federal approval. While this measure, as its title indicates, refers to welfare, it necessarily includes such things as medical, dental and nursing care as well as pharmaceutical service and there is no well defined limit as to what may be included under welfare. Let us not be misunderstood. Our objection is not to the commendable features of this measure which tend to economy and therefore greater efficiency in the administration of this important work; it is to the centralization of authority which appears to be the trend of political movement. Let us have as much decentralization and therefore freedom as possible. John Stuart Mill in his famous essay on Representative Government wrote:

"A people may prefer a free government; but if, from indolence, or carelessness or cowardice, or want of public spirit, they are unequal to the exertions necessary for preserving it; if they will not fight for it when it is directly attacked; if they can be deluded by the artifices used to cheat them out of it; if, by momentary discouragement, or temporary panic, or a fit of enthusiasm for an individual, they can be induced to lay their liberties at the feet even of a great man, or trust him with powers which enable him to subvert their institutions—in all these cases they are more or less unfit for liberty; and though it may be for their good to have had it even for a short time, they are unlikely long to enjoy it."

WE WOULD FAVOR RECIPROCITY

THE United States continues to be a very attractive country to outside physicians looking for a location to practice medicine. Ten years ago, thirty-six physicians from Austria, Germany and Italy located in the United States. In 1938 to date, the number is 390. Many of these physicians are well trained and have occupied teaching poistions in some of the most noted schools of medicine in Europe. The various states of the United States have been somewhat liberal in admitting medical graduates from other countries. We see no objection to the admission of qualified physicians who have met all the requirements of the state board of the state in which they seek license. What we do not like is the refusal to admit members of the American medical profession to practice in foreign countries. The liberality in the admission of graduates from other countries to the United States should be at least proportionate to the welcome extended graduates of our own medical schools who may seek a license to practice in those countries.

CONTACT THE COUNTY MEDICAL SOCIETY

THE *Genesee County Medical Society Bulletin* quotes the following from Hertzler, "The Horse and Buggy Doctor":

"We hear that there are a lot of tears shed nowadays because one-third of this great 'American People' are without adequate medical care. I wonder where these persons live. I know this country from the Father of Waters west and they are not here, * * * This line of conversation seems to emanate from the same Fount of Wisdom that urged us Kansans to plow up our pasture and sow wheat, and that now advises us to put the grass back and plant shade trees and then give the land back to the Indians and buffaloes. Really, it does seem that a good deal of grief could be spared if people would continue their vociferations to things they know something about or at least to regions where their ignorance is not so conspicuous. Why fools are endowed by nature with voices so much louder than sensible folks possess is a mystery. It is a fact emphasized throughout history.

"Certainly, thousands of people do not have adequate medical care, but it is not because it is not accessible to them. * * *

"* * * Who judges whether or not there is adequate medical care? It is wrong assumptions here that are leading to disastrous conclusions."

These paragraphs call to mind excerpts from the *New Orleans Medical Journal,* published in the September number of this JOURNAL, commenting on Dr. Cabot's statement before the National Health Conference in Washington, to the effect that thousands of young physicians are starving and that the bulk of the lower third of the population is not receiving medical care. We feel, like Dr. Hertzler and also the brilliant editor of the *New Orleans Medical Journal,* that medical care is to be had, and if people do not seek it, who is to blame? Many persons, for reasons best known to themselves, never patronize members of the medical profession. They are inclined to consult cultists and irregulars. Others again refrain from consulting physicians through fear. The physician is not only a symbol of hope, he is also a symbol of the opposite, and many keep away for fear of unwelcome news of their condition that they might hear. What more, however, can a physician do than to endeavor constantly to improve his mental equipment and therefore render a higher degree of medical care for those who seek his services. For those who refuse to consult him, he can do nothing. The fact, however, as announced by Dr. Haven Emerson in Detroit, that the past year has seen the United States the healthiest country in the world so far as morbidity and mortality are concerned, should exonerate the medical profession from the charge of hiding its light under a bushel.

Families or persons in need of medical care should call up or seek advice from the headquarters of the county medical society. Were they informed to do so through the public press, or otherwise, the problem of the distribution of medical care would largely be taken care of.

Everyone has *some* problem. I never met a completely trouble-free man. It is a sort of compensating law of Nature that if a man is free from financial troubles, say, then he has health troubles or home troubles, or a very exacting and demanding job. If you do not believe this, just ferret about among your friends and you will find that every one of them has some secret trouble or grievance about which they say little but brood much.—A writer in *"Modern Salesmanship,"* London.

DR. C. D. HART, COUNCILLOR OF THE 12TH DISTRICT

Dr. Clarence Dunbar Hart of Newberry has been elected councillor for the twelfth district. Dr. Hart was born at Cambridge, Massachusetts, on June 19, 1895. He is a graduate of Harvard University with the degrees of B.S., M.D., and C.P.H. He is District Health Officer at Newberry, Michigan. He is also secretary of the Luce County Medical Society and a member of the Public Relations Committee and Preventive Medicine Committee of the State Society. Dr. Hart's election augurs well for his District. His scholarship and experience will prove valuable to his constituents as well as to the State Medical Society as a whole.

C. D. HART, M.D.

Councilor of the 12th District, comprising the counties of Chippewa-Mackinac, Delta-Schoolcraft, Luce and Marquette-Alger.

THE WRITING OF CASE HISTORIES

THE proper writing of case histories appears to be a puzzle to a great many medical writers. This is probably due to the hospital training, or lack of it, whereby certain forms are used, partly printed, so that data may be added by means of single words or phrases. How often, in listening to an account of a clinical case, do we find the speaker give a very satisfactory explanation and comment after presenting his case history as a jumble of phrases or implied sentences, *sans* predicate or *sans* subject. An effort has been made to emphasize the

importance of devoting as much care to the diction of the case history as is bestowed on the paper itself which is submitted for publication. We would strongly urge any would-be medical writer to read some of the case histories which appear in our national journals, or journals devoted to medical and surgical specialties, in order to see what is acceptable for publication. We have emphasized the necessity of complete statements of fact. The author should leave nothing to be implied by the reader.

Now, in regard to abbreviations, we have the following timely advice in an editorial which appeared in a recent number of The *Journal of the American Medical Association:*

"When abbreviations are used in medical papers, in the recording of case histories or physical examinations or in operative or pathologic reports, the meaning should be entirely clear to all who may have occasion to read them. This is not, of course, the case. Abbreviations of medical terms are used obviously to save the time of the writer; too often, however, the time thus saved is wasted many times over by the person who is trying to decipher the meaning originally intended. When placed within a context, many of the abbreviations commonly employed in medicine are reasonably clear to those intimately familiar with the particular field; but when removed from such environment they become even more abstruse. Few readers, for example, can probably identify with ease such fairly commonly employed abbreviations as M. T. R., PcB, P. P. D., M. E. D., s. e. d., M. K. R. or K. P. Even when the abbreviations are placed in the proper setting many medical men would have difficulty in translating PcB into "near point of convergence," M. T. R. into "Meinicke flocculation reaction" or M. E. D. into "minimal erythema dose."

"Although for the uninitiated the ophthalmologists possess probably the worst collection of uninterpretable abbreviations, such as K. P. for "keratitis punctata," Hm for "hyperopia manifest," O. U. for "occulus uterque (both eyes)," M. A. for "meter angle" and so on almost ad infinitum, those in other fields are by no means free of criticism. The average physician would usually interpret P. S. P. as the "phenolsulfonphthalein test," M. L. D. as "minimal lethal dose" and possibly P. P. D. as "purified protein derivative" but others who also may need to translate such initials, including manuscript editors, social service workers and statisticians, may have serious difficulties. Sometimes the attempt at interpretation gives rise to persistent errors of more or less serious nature, such as the reasonable interpretation of E. coli as "Endamoeba coli" when it should have been "Escherichia coli."

"Hours sometimes have been spent in attempting to decode the meaning of such abbreviations. The use of such short cuts to expression may be an indication of unnecessary haste, careless recording of notes, or slipshod methods of experimentation and study. Reports are written for the reader, not the author, and the reader should not have to be an expert in cryptography to find out what it is all about."

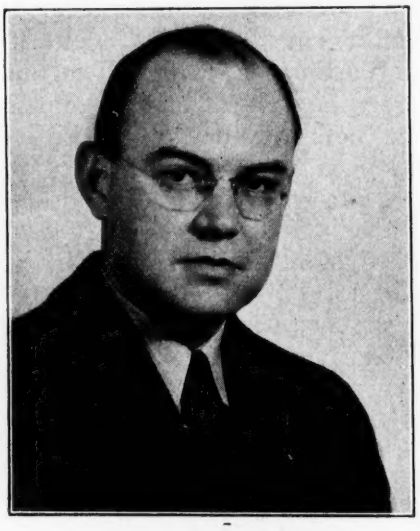
Reward

Work and save, young man, and some day you'll have enough to divide with those who don't.

Niagara Falls *Review.*

DR. W. H. HURON, COUNCILLOR OF THE 13th DISTRICT

Dr. W. H. Huron of Iron Mountain, the newly elected Councillor of the 13th District, comes to his new position with a background in medicine, which should mean much to the Society. The son of a physician, he was born at Tipton, Indiana, June 23, 1900. He is a graduate of Ohio State University and did postgraduate work with an internship and residency in surgery at Henry Ford Hospital, Detroit. He is a fellow of the American College of Surgeons and is secretary of the Dickinson-Iron County Medical Society. He has practiced his profession at Iron Mountain for the past nine years.



W. H. HURON, M.D.

Councillor of the new 13th District, comprising the counties of Dickinson-Iron, Gogebic, Houghton-Keweenaw-Baraga, Menominee and Ontonagon.

Criticism

Reading his newspaper one morning, a man came across an article in which he was severely criticized. He was furious at the insult and asked a friend how to take vengeance. Should he challenge the author of the article to a duel? Demand a public apology? Sue him?

But the friend was a philosopher.

"You will do none of these things," he replied calmly. "Half the people who have read the paper didn't see the article. Half of those who did see it didn't read it. Half of those who read it didn't understand it. Half of those who understood it didn't believe it. Half of those who believed it were of no importance anyway."—*L'Oeuvre,* Paris.

President's Page

WIN THE BALL GAME

THE Michigan State Medical Society is at bat in the last half of the ninth inning with the score tied. The winning run is on second base. Can you hit a safe single?

A hit means a win. A strikeout means a tie, with possible loss of the game. "Step into it," take a positive and decisive stance with carefully worked out plans to meet the problem of hospital insurance and medical care where need is shown to exist. Ball games are not won the next day. Don't be a mighty Casey and strike out! Hit the ball!

Henry B. Luce

President, Michigan State Medical Society.

DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

DOES THE FEDERAL GOVERNMENT SEEK TO SOCIALIZE MEDICINE?*

By HON. PAUL W. SHAFER
U. S. Congressman, Third District, Michigan
Battle Creek, Michigan

NATURALLY I would not attempt to give a direct answer to this question, but, judging from the various and many activities of the Administration in Washington, I believe it is safe to say that definite steps to socialize medicine will soon be taken unless medical and dental societies act quickly to bring about a greater distribution of medical and dental care to the indigent of the nation, and to those of the low income group.

Men and women of America, hade conscious of the health problems of the nation's poor by a clever campaign of propaganda that, during the past two or three years, has reached into practically every home, are today demanding of government that something be done to solve this problem. They are demanding that something be done to ease the burden that comes when ill health strikes their loved ones. And, all must admit, it is a reasonable demand.

While the campaign for socialized medicine has been steadily gaining ground in America, medical and dental organizations have been quietly seeking to bring greater distribution of medical care to the nation's needy. The mistake that has been made, as I see it, is that until recently the public was not informed of the fact that a solution to this problem was being sought.

Only last week the American Medical Association let it be known that it has long recognized the seriousness of this problem and that it has taken definite steps to solve it.

I was glad to read in the newspapers that the A.M.A. House of Delegates, meeting in Chicago, had agreed with the report of the National Health Conference, held in Washington in July, that "the health of the people of this nation is of direct concern of the government and the health of the impoverished and those of lower income groups must be protected."

The decision of the House of Delegates to favor hospital service insurance, expansion of the U. S Public Health Service, the establishment of a Federal department of Health, and other recommendations made by the National Health Conference, indicates that the American Medical Association stands ready to coöperate with the Federal Government, which is necessary if a free medical profession is to continue in America.

Bring relief to the indigent, including those receiving old age pensions, who have so far been neglected, and those on WPA, and the clamor for socialized medicine will cease. This will require coöperation on the part of all medical men and the government. I do not propose to say whether this greater distribution of medical care should be subsidized, but, no doubt this must be considered.

From all I have been able to observe there never has been any complaint from those urging socialized medicine as to the quality of medicine in America. The only complaints heard have been based on the poor distribution of medical service in some areas. Solve this problem and you will, for all time, silence those who are agitating socialized medicine.

*Address delivered before the Battle Creek Academy of Medicine and Dentistry, September 27, 1938.

"M.D. VERSUS DOCTOR"

AMONG the many changes in our daily experience is the significance of the title "Doctor." Time was when the use of that term implied certain educational achievements and professional attainments. As a degree, it was conferred by institutions of recognized standards. In recent years, the title "Doctor" has lost much of its traditional significance. It has been conferred by institutions of no recognized standards and upon individuals with not even minimal educational achievements.

A glance at any office building directory will disclose a list of "Doctors" ranging from the rankest cultist to the legitimate

practitioner of medicine. The appellation, to the layman, carries no differentiating significance.

In view of these facts, it behooves the practitioners of medicine to relinquish the term "Doctor" and use the qualifying degree of "M.D." This is still significant and belongs only to an individual who has pursued prescribed courses of study and has proven himself worthy of its traditions.

THE GOVERNOR'S SPEECH

GOVERNOR FRANK MURPHY, in sending copy of an address which he gave at the Michigan Health Conference at East Lansing on September 10, wrote to each medical practitioner in the state that he "wishes the medical profession of Michigan, with its nearly 5,000 progressive members, to know that it has the support of the government of this state in planning a more nearly adequate program of health for the people."

"That most valuable resource of the state—human life—must be protected," stated Governor Murphy. "An enlightened government can do much to assist the physician in supplying more and better medical care to those now unable to obtain it. I fully realize, however, that any new program must in no way interfere with the excellent work now being done by the profession. We wish, rather, to supplement that work.

"The coöperation of the individual physician, as well as of the organized medical groups, is needed in order that we shall be able to build soundly and wisely for the present and the future."

MICHIGAN PHYSICIANS PRESCRIBE

"FEDERALIZED MEDICINE" was discussed by Henry A. Luce, M.D., of Detroit, President of the Michigan State Medical Society, before the Chamber of Commerce Forum in Lansing, October 19.

Dr. Luce demanded that government authorities, charged with furnishing necessities to the indigent, must make means available so that the people of Michigan who need medical care shall have it distributed to them in good and sufficient quantity and quality, "when they want it, from whom they want it, and under such circumstances as our training and experience have taught us is the best."

"The health of the people of this country has too long been a controversial subject," according to Dr. Luce. "During recent years, various non-medical groups have attained prominence by attempting to prescribe the health services of our country. The most recent action was that of a committee designated as 'The Technical Committee.' Just what is meant by technical in this case is rather ambiguous. It is reasonable to assume that it was not entirely non-political.

"The American Medical Association's House of Delegates last month in Chicago wrote a prescription for our country. Michigan physicians, who are all in accord with the national policy, demand that our Michigan public have the best care available. There is not one kind of care for the unfortunate and another for the well-to-do. We recognize no class, creed, color or economic and social dividing lines. We insist upon the proper authorities making means available that we may achieve our objectives. We have written the prescription. We shall write others as the need arises. The 'pharmacists' are the legislative bodies, both Federal and State. The Michigan medical profession will tolerate no substitutions or nostrums."

POSTGRADUATE MEDICAL EDUCATION

THE FIRST Postgraduate Convocation, held at the time of the 1938 Annual Meeting, demonstrated the profession's appreciation of the Society's efforts in the field of education. On that occasion, over five hundred members of the Michigan State Medical Society became eligible for the first award, a Certificate of Associate Fellowship in Postgraduate Medical Education. Most of the eligible members presented themselves, in person, for the award. From year to year, like numbers will become eligible for the certificate on the basis of a four-year period. The second period award will be that of Fellowship.

The unique plan, as instituted in Michigan, brings the latest achievements in scientific medicine to the very door of the practitioner. Due to the great size of the State of Michigan and the distribution of physicians, it is very inconvenient and impractical for many practitioners to attend organized courses at the educational institutions. For this group, the weekly lecture plan offers an unusual opportunity for advanced medical education.

To its chairman, James D. Bruce, M.D., and the Committee on Postgraduate Medical Education, too much commendation cannot be given. The growing popularity of the program and the presence of so many enthusiastic members at the convocation are evidences of appreciation.

WOMAN'S AUXILIARY

President—Mrs. P. R. Urmston, 1862 McKinley Avenue, Bay City, Michigan
Sec.-Treas.—Mrs. R. E. Scrafford, 2210 McKinley Ave., Bay City, Michigan
Press—Mrs. J. W. Page, 119 N. Wisner Street, Jackson, Michigan

PRESIDENT'S MESSAGE

It is my turn to serve this year the Woman's Auxiliary of the Michigan State Medical Society as president.

MRS. P. R. URMSTON

I wish to acknowledge my deep appreciation to the Board and Auxiliary members of the privilege of attending the national meeting held in San Francisco last June. It is my hope, from the knowledge gained and the contacts I made while there, to further our interests in Auxiliary work.

The program I shall attempt to carry out will be a continuation of the policies of the past years.

In Doctor Collisi's report, as chairman of the Advisory Committee of the Woman's Auxiliary, May 12, 1938, he recommends the following activities:

1. Organization of a woman's auxiliary for each county medical society.
2. That each auxiliary member become civic minded; be a good club woman; and be a member of as many community groups as possible.
3. That she inform herself on state medicine in order to give the medical point of view.
4. That she become a member of the Michigan Health League.
5. That the woman's auxiliary assist the state medical society in its program on public health education; promote radio health programs sponsored by the medical society; and stimulate public interest in social hygiene, cancer education, tuberculosis, syphilis and maternal health problems.

In closing he adds the following:

"The advisory committee realizes the great importance of a woman's auxiliary to the state medical society. The constantly changing social, economic and professional structure of our national government has created many controversial medical questions that need to be intelligently explained to the laity. Women's organizations have always been valuable adjuncts to those of men. Today, more than ever before, man realizes the need of the woman's help in his government, his business and his profession.

"The advisory committee wishes to pay a tribute to the doctors' wives of Michigan for their unselfish interest and splendid coöperation in the mutual problems that have arisen during the year."

State Convention registration report:

Woman's Auxiliary—121 registrations. A total membership, 933. Michigan State Medical Society —2,007 registrations. Total membership, 4,077.

These reports speak for themselves, and I urge each county president to impress upon her auxiliary members the importance of attending the state meetings—*and registering.*

In the past years much time and effort has been spent in preparing a splendid program for the state meetings. This effort has not been made for Board members, standing committees and delegates alone but for *all* auxiliary members. It is *your* meeting —the event of the year.

We have loyal, well informed women in every county auxiliary, and from these groups we must choose our future leaders.

I speak from experience when I say to you that the more interest you take in state organization work, the more successful will be your local auxiliary.

In closing, in behalf of my Board members, standing committees and myself, we ask:

Guidance from our national organization.

Action from our Advisory board of the M.S.M.S.

MRS. P. R. URMSTON, *President.*

Past Presidents Receive Pins

At the Wednesday morning session of the Woman's Auxiliary during the recent state meeting, the past presidents of the organization were presented with pins in recognition of their services to the Auxiliary. These pins are of solid gold in green-gold finish. They bear a half caduceus on a filigree background mounted in an olive wreath within the circle of which is engraved "Past President W.A.M.S.M.S." The presentation was made by Mrs. Charles Tomlinson, President, Woman's Auxiliary, American Medical Society. Those who received the pins were: Mrs. Guy L. Kiefer, Detroit, 1927-28; Mrs. L. J. Harris, Jackson, 1929-30; Mrs. J. Earle McIntyre, Lansing, 1931; Mrs. F. A. Mercer, Pontiac, 1932; Mrs. E. L. Whitney, Detroit, 1933; Mrs. F. T. Andrews, Kalamazoo, 1934; Mrs. A. M. Giddings, Battle Creek, 1935; Mrs. A. V. Wenger, Grand Rapids, 1936; Mrs. G. C. Hicks, Jackson, 1937.

MRS. F. A. MERCER

A pin of similar design executed in silver was given to the acting President, Mrs. P. R. Urmston, to be worn during her term of office and to be passed on to her successor.

Report of Annual Meeting

The Twelfth Annual Session of The Woman's Auxiliary to the Michigan State Medical Society convened at Hotel Statler, Detroit, September 19 to 21.

The Pre-convention Board meeting of the 1937-8 Board was held at the Woman's City Club, September 20. Following a luncheon, the meeting was called to order by the president, Mrs. G. C. Hicks. The following responded to roll call—Officers: Hicks, Urmston, Christian, Page, Wenger, Kiefer; Committee, Chairmen: Jetnichen, Pyle, Fulkerson, Christian, Geib, Keagle, McIntyre and Whitney; County Presidents: Lang, Snapp, Harvie, Walker, Reisig, and Malcomb.

The minutes of the previous meeting were read and approved.

Chairmen of standing committees were given opportunity to discuss the problems of their work. Those who responded were Mrs. Jeanichen, program chairman, and Mrs. Fulkerson, press chairman.

Mrs. Geib, chairman of revision, read the proposed amendments to the Constitution and By-Laws

and moved their adoption by the Board. After discussion, the motion was approved by a majority vote.

Discussion led by the chairman of the Hygeia Committee, Mrs. Keagle, brought the suggestion, approved by the Board, that a letter of protest be sent to the national Hygeia chairman against the method of encouraging late subscriptions by cutting rates. It was felt that this was unfair to earlier subscribers.

The county presidents were invited to talk over any problems in their field but none responded.

The president presented and explained the national budget and gave items of interest from the national convention in San Francisco, telling of our own exhibit and those of other states and outlining some of the projects which have been undertaken by state and national auxiliaries.

The meeting was adjourned by the president at 3:50 P. M.

* * *

The annual meeting was held in the Ivory Room of the Hotel Statler, Wednesday, September 21. The meeting was called to order at 10:30 A. M. by the president, Mrs. G. C. Hicks. The Address of Welcome was given by Mrs. Ledru Geib, representing the hostess auxiliary, Detroit, and Mrs. Guy L. Kiefer responded for the convention.

Led by Mrs. James H. Dempster, the convention paid tribute to the memory of Mrs. A. A. Francis, Saginaw; Mrs. J. Newell Holcomb, Kent County; Mrs. Frederick T. Reid and Dr. Alice Corbett, Oakland County; Mrs. Leonard F. C. Windt and Mrs. Van Valen, Wayne County.

The minutes of the previous meeting were read and approved.

The treasurer's report for the year was read, showing a balance of $375.03. It was approved. The report of the auditor of the treasurer's report was read.

The reports from the following standing committees were received and placed on file:

Program .....Mrs. Jeanichen
Press .....Mrs. Fulkerson
Organization .....Mrs. Pyle
Legislation .....Mrs. Christian
Hygeia .....Mrs. Keagle
Historian .....Mrs. McIntire

The Committee on Revision, Mrs. Geib, chairman, proposed amendments to the Constitution and By-Laws as recommended by the Advisory Committee. Mrs. Geib read the amendments and moved their acceptance. Mrs. Whitney seconded the motion. It was moved by Mrs. Kiefer, seconded by Mrs. Hoffman, that the matter be laid on the table until the membership had further time for study and consideration. This motion passed and it was so ordered.

Reports of county chairmen were received as follows:

Bay—read by.....Mrs. Scrafford
Calhoun .....Mrs. Howard
Eaton .....Mrs. Anderson
Ingham .....Mrs. Vanderzalm
Jackson—read by.....Mrs. Aler
Kalamazoo .....Mrs. Lang
Kent .....Mrs. Snapp
Oakland .....Mrs. Sutton
(written by Mrs. Z. Rooks)
Ottawa—read by.....Mrs. Tappen
Saginaw .....Mrs. Harvie
Wayne .....Mrs. Walker
Monroe .....Mrs. Bond
for Mrs. Reisig
Lapeer .....Mrs. Merz

Mrs. Robert Jamieson, Committee of Credentials and Registration, reported a registration of 121 of whom 38 were from Wayne County. The report of the Advisory Committee was read by the secretary, accepted and placed on file.

With the vice president, Mrs. Christian, in the chair, the president, Mrs. G. C. Hicks, gave a splendid report for the year. She was accorded an ovation preceding and following her report.

The Committee on Nominations, Mrs. Harvie, Mrs. Geib and Mrs. Peterson, presented the names of Mrs. L. G. Christian of Lansing for president-elect and Mrs. Roger V. Walker, Detroit, for vice president. There being no other nominations for either office, these nominees were elected by acclamation.

Mrs. Emma Fox, a guest at the meeting, was introduced by the president and addressed the meeting briefly.

The secretary read a letter requesting that the Woman's Auxiliary go on record as supporting the proposed Michigan bill, modeled on the Oregon bill, for the control of the sale of contraceptives. On motion of Mrs. Robb, supported by the assembly, the matter was referred to the Legislative Committee of the State Medical Society.

The Committee on Resolutions, Mrs. Wenger, Mrs. Straith, and Mrs. Scrafford, presented resolutions expressing the appreciation of the convention for the cordial hospitality of the Wayne County Auxiliary, in according needs and courtesies to the delegates and guests. These were adopted. Mrs. Hoffman moved that the secretary be instructed to write a letter of cheer to the convention chairman, Mrs. A. O. Brown, who was kept away by illness. The motion was adopted.

The newly elected officers for the year 1938-39 were introduced by the president, following which the new president, Mrs. P. R. Urmston, was seated in the chair.

President Urmston introduced Mrs. Charles Tomlinson of Omaha, Nebraska, president of the Woman's Auxiliary of the American Medical Association, who graciously addressed the past presidents of the Michigan Auxiliary and conducted an impressive ceremony whereby they were each presented with a pin in appreciation of their services to the organization. The acting president also received a pin which she will pass on to her successor at the end of her term of office.

The meeting was adjourned by the president at 12:20 P. M.

* * *

At the banquet in the Hotel Statler, Mrs. Hicks, president, presided; she and the Executive Board were resplendent in gifts of gardenia shoulder corsages.

Two notable speakers held the attention of the 150 guests: First, Dr. Morris Fishbein, chairman of the Advisory Council, Woman's Auxiliary, A.M.A., gave a dynamic speech from which we trust each county president carried home copious notations for her Auxiliary. Dr. Fishbein was accorded a rising vote of thanks for his courage in holding high the banner of the true science of medicine. The second speaker was Mrs. Lawrence Hess, an extension lecturer for the University of Michigan in the field of social hygiene. She worked during the past summer with the Kellogg Foundation as a consultant in that field. Her address had to do with a well rounded program of social hygiene and followed somewhat the line of thought pictured in the posters which comprised the Michigan State exhibit at the San Francisco convention. Mrs. Hess and Mrs. Hicks conceived the idea of the exhibit which was executed in Grand Rapids under the direction of Mrs. Butler.

The posters were on display at the state meeting on Wednesday morning. They are available to any group who wishes to use them, and may be obtained by writing Mrs. Urmston, president, Bay City.

* * *

The closing session of the convention was the luncheon at the Colony Club on Wednesday and included among the honored guests, our national president, Mrs. Chas. Tomlinson; Dr. Henry Cook, president, M.S.M.S.; Dr. H. A. Luce, president-elect, M.S.M.S.; Dr. L. F. Foster, secretary, M.S.M.S.; Dr. H. R. Carstens, president, W.C.M.S.; Mrs. Guy Kiefer, honorary president, Woman's Auxiliary, M.S.M.S. Again our president, Mrs. Hicks, and national president, Mrs. Tomlinson, were recipients of shoulder corsages of orchids.

The chief address was made by Dr. H. S. Collisi, chairman of the Advisory Committee, Women's Auxiliary, on "Marriage After Forty." So many requests were made for copies of his very illuminating address that he promised mimeographed copies would be made.

Adjournment was followed by the post-convention Board meeting, Mrs. P. R. Urmston, newly elected president, presiding. The new committee chairmen were named.

Appreciation is extended Mrs. Page, retiring secretary, for complete data furnished for this report; also abiding good wishes to her as my successor.

(Mrs. C. B.) Cora K. Fulkerson,
State Press Chairman.

American Academy of Pediatrics

The American Academy of Pediatrics, Region III, held its 8th Annual Meeting in Detroit on October 27, 28 and 29. The program was very full and complete and provided an intensive postgraduate course on the subject of pediatrics. The editor regrets that the program was received too late in the month to serve as an announcement to the medical profession.

Free Medical Assistance Ends for Wealthy Indians

Free medical service for all Indians regardless of wealth is a thing of the past. From now on those who can afford it must pay for treatment.

The charge system, put into effect July 1, is the first step toward making the Indian medical service self-supporting, officials say. Officials do not believe wealthy Indians should receive free medical service.

Treatment still will be provided for destitute Indians without cost.—*Detroit Free Press,* Sept. 14, 1938.

OBESITY IN ADOLESCENT CURED WITHOUT INJECTIONS

Horace Gray, San Francisco (*Journal A.M.A.,* April 30, 1938), observed two boys with obesity, genital hypoplasia, marked tallness and eunuchoid legs for four years (from 12 to 16) and for five years (age 14 to 19), with diet but no endocrine injections. During observation their builds became sufficiently normal to eliminate any question of the need of added hormone. Treatment was begun by the author's usual obesity diet of carbohydrate 80, protein 60, fat 40 Gm., namely, a bread and flour free regimen but including milk and vitamins. The food was not weighed by either of these patients. As soon as they had shown coöperation in facing the restrictions, the diet was increased, mainly to give a protein of about 1.5 Gm. per kilogram of body weight normal for the patient's age and height. Improvement in slenderization in the first patient is most clearly shown by the weight/stature index as converted into terms of percentile rank; whereas "before" the patient was fatter for his height than 98 per cent of boys of his age, "after" the period of treatment he was fatter than only 76 per cent; that is, 24 per cent of boys his age would be as fat as he.

Proceedings of House of Delegates—1938

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*Proposed Amendments to Constitution or By-Laws.

MICHIGAN STATE MEDICAL SOCIETY

SEVENTY-THIRD ANNUAL MEETING

Proceedings of House of Delegates

Book-Cadillac Hotel, Detroit, Michigan

September 19, 1938

Monday Morning Session

September 19, 1938

The First Session of the Annual Meeting of the House of Delegates of the Michigan State Medical Society was called to order at nine-fifteen at the Book-Cadillac Hotel, Detroit, Michigan, Dr. Philip A. Riley, the Speaker, presiding.

The following is the roll call for the three sessions:

RECORD OF ATTENDANCE

	COUNTY	DELEGATE	Session 1st	2nd	3rd
1.	Allegan	E. T. Brunson, M.D.	x	x	x
2.	Alpena	F. J. O'Donnell, M.D.	x	x	x
3.	Barry				
4.	Bay-Arenac-Iosco-Gladwin	R. C. Perkins, M.D.	x	x	x
5.	Berrien	Wm. C. Ellet, M.D.	x	x	x
6.	Branch	Robt. L. Wade, M.D.	x	x	x
7.	Calhoun	Harvey Hansen, M.D.	x	x	x
		A. T. Hafford, M.D.	x	x	x
		S. L. Loupee, M.D.	x	x	x
8.	Cass	E. S. Rhind, M.D.	x	x	
9.	Chippewa-Mackinac	D. W. Scott			x
10.	Clinton	A. C. Henthorn, M.D.	x		
		Dean W. Hart, M.D.	x	x	x
11.	Delta	O. S. Hult, M.D.	x	x	
12.	Dickinson-Iron	E. M. Libby, M.D.	x	x	x
13.	Eaton	Ed. Imthun, M.D.	x	x	x
14.	Genesee	Frank E. Reeder, M.D.	x	x	x
		Robert Scott, M.D.	x	x	x
		Donald R. Brasie, M.D.	x	x	x
15.	Gogebic				
16.	Grand Traverse-Leelanau-Benzie	C. E. Lemen, M.D.	x	x	x
17.	Gratiot-Isabella-Clare	Myron C. Becker, M.D.	x	x	x
18.	Hillsdale	L. W. Day, M.D.	x	x	x
19.	Houghton-Baraga-Keweenaw	G. M. Waldie, M.D.	x	x	x
20.	Huron-Sanilac	J. C. Webster, M.D.	x	x	
21.	Ingham	R. L. Finch, M.D.	x	x	x
		C. F. DeVries, M.D.		x	x
		H. W. Wiley, M.D.	x	x	x
22.	Ionia-Montcalm	L. E. Kelsey, M.D.	x	x	x
23.	Jackson	Philip A. Riley, M.D.	x	x	x
		James J. O'Meara, M.D.	x	x	x
24.	Kalamazoo-Van Buren	Charles TenHouten, M.D.			
		R. J. Hubbell, M.D.	x	x	x
		Fred M. Doyle, M.D.	x	x	x
25.	Kent	A. V. Wenger, M.D.	x	x	x
		C. F. Snapp, M.D.	x	x	x
		P. W. Kniskern, M.D.	x	x	x
		G. H. Southwick, M.D.	x	x	x
		W. R. Torgerson, M.D.	x	x	x
26.	Lapeer	Herbert M. Best, M. D.	x	x	x
27.	Lenawee	A. W. Chase, M.D.	x	x	x
28.	Livingston	H. Huntington, M.D.	x	x	x
29.	Luce	R. E. Spinks, M.D.	x	x	x
30.	Macomb	R. F. Salot, M.D.	x	x	x
31.	Manistee	E. A. Oakes, M.D.	x	x	x
32.	Marquette-Alger	Vivian Vandeventer, M.D.	x	x	x
33.	Mason	R. Farrier, M.D.	x	x	
34.	Mecosta-Osceola-Lake	G. H. Yeo, M.D.	x	x	x
35.	Menominee	H. T. Sethney, M.D.	x	x	x
36.	Midland	Edwin Place, M.D.	x	x	x
37.	Monroe	D. C. Denman, M.D.	x	x	x
38.	Muskegon	E. L. Foss, M.D.	x	x	x
		E. N. D'Alcorn, M.D.	x	x	x
39.	Newaygo	O. D. Stryker, M.D.	x	x	
40.	Northern Michigan	C. B. Saltonstall, M.D.	x	x	x
41.	Oakland	Otto O. Beck, M.D.	x	x	x
		Palmer E. Sutton, M.D.	x	x	x
		Zea Aschenbrenner, M.D.			
42.	Oceana	N. W. Heysett, M.D.			
43.	O.M.C.O.R.O.	C. R. Keyport, M.D.	x	x	
44.	Ontonagon	W. F. Strong, M.D.	x	x	x
45.	Ottawa	A. E. Stickley, M.D.	x	x	x
46.	Saginaw	Clarence E. Toshach, M.D.	x	x	x
		L. C. Harvie, M.D.	x	x	x
47.	Schoolcraft	James H. Fyvie, M.D.	x	x	x
48.	Shiawassee	A. L. Arnold, M.D.	x	x	
49.	St. Clair	A. L. Callery, M.D.	x	x	x
50.	St. Joseph	R. A. Springer, M.D.	x	x	x
51.	Tuscola	T. E. Hoffman, M.D.	x	x	x
52.	Washtenaw	John A. Wessinger, M.D.	x	x	
		Dean W. Myers, M.D.			
		L. J. Johnson, M.D.	x	x	x
53.	Wayne	T. K. Gruber, M.D.	x	x	x
		J. M. Robb, M.D.	x	x	x
		C. E. Umphrey, M.D.	x	x	x
		Ralph H. Pino, M.D.	x	x	x
		E. D. Spalding, M.D.	x	x	x
		R. M. McKean, M.D.	x	x	x
		H. W. Plaggemeyer, M.D.	x		
		R. C. Andries, M.D.	x		x
		R. L. Novy, M.D.	x	x	x
		Wm. R. Clinton, M.D.	x	x	x
		A. E. Catherwood, M.D.	x	x	x
		W. D. Barrett, M.D.	x	x	x
		Douglas Donald, M.D.	x	x	x
		Grover C. Penberthy, M.D.	x	x	x
		Louis J. Hirschman, M.D.	x	x	x
		R. C. Jamieson, M.D.	x	x	
		Fred H. Cole, M.D.	x	x	x
		C. E. Simpson, M.D.	x	x	x
		C. S. Kennedy, M.D.	x	x	x
		H. F. Dibble, M.D.	x	x	x
		Andrew P. Biddle, M.D.	x	x	x
		C. E. Dutchess, M.D.	x	x	x
		Alexander W. Blain, M.D.	x	x	x
		Warren B. Cooksey, M.D.	x	x	x
		David I. Sugar, M.D.	x	x	
		Wm. J. Stapleton, Jr., M.D.	x	x	x
		P. L. Ledwidge, M.D.	x	x	x
		C. E. Lemmon, M.D.	x	x	x
		J. A. Hookey, M.D.	x	x	x
		C. K. Hasley, M.D.	x	x	x
		C. F. Brunk, M.D.	x	x	x
		S. W. Insley, M.D.	x	x	x
		L. J. Bailey, M.D.	x		x
		R. L. Laird	x	x	x
		M. H. Hoffmann, M.D.	x	x	x
54.	Wexford	W. Joe Smith, M.D.	x	x	x

The reference committees were appointed.

Dr. Martin H. Hoffmann, Vice Speaker, took the chair.

THE VICE SPEAKER: Next is the address of Speaker Riley.

I. SPEAKER'S ADDRESS

The Speaker read his prepared address:

DR. PHILIP A. RILEY: Mr. Vice Speaker, officers of the Michigan State Medical Society and members of the House of Delegates:

Once again time has rolled around the day of our annual meeting. It is a day of reckoning, if you like—accounting for our deeds of the past year. It is also a day of planning—for more than ever our future should be well outlined.

The House of Delegates, when in session, is the supreme body of our organization. You have drafted the constitution by which we are guided and it is your duty to amend it as the need may arise. You have compiled the by-laws under which we operate and you elect the officers to carry on for you while you are not in session. The officers of the society as well as the committees they have

appointed are accountable to you for their accomplishments during the past year.

During the past year, the work of the society has been very ably conducted by the Executive Committee of the Council. As your representative on that committee, I have had ample opportunity to observe the untiring efforts of these gentlemen, and I want to say right now that this society owes a big debt of gratitude to Dr. Henry Cook, our president; to Dr. Paul Urmston, Chairman of the Council; and to our hard working secretaries, Dr. Foster and Mr. Burns. Time away from the practice of medicine seems to mean nothing to these gentlemen. With them the society comes first. There is only one conclusion one may draw—they must be wealthy.

For the past few years, the business end of our society has grown by leaps and bounds. I think I am conservative when I say that it has increased 400 per cent in the last 5 years.

We have twenty active standing committees which will render a report today. Many of these reports will contain recommendations for our future policies. The acceptance and adoption of these recommendations constitutes our future policy. With this in mind it behooves each member of a reference committee to put forth his best efforts in formulating these recommendations.

When we say that the business end of our society has increased, we include the work of the committees. It is more than an honor today to be placed on a committee. It is a duty which carries with it an obligation—an obligation to improve the quality of medical service available to the people of Michigan.

The work carried on by the Committee on Postgraduate Education is unsurpassed. Through its efforts new discoveries and improved methods of diagnosis and treatment are carried to all sections of the State. The people of Michigan are the real beneficiaries of this work.

The obligations imposed upon our Legislative Committee are necessary because of the nature of our government. It is ever changing. New laws by the score are enacted every session of the legislature. It is the duty of our legislative committee to oppose laws which may be detrimental to the health of the people of Michigan and by the same token to help in the passage of beneficial measures.

There are people who claim this activity is motivated only by selfish interests. Such is not the case. For centuries past the protection of the people has been our God-given command. For it is written, "Give place to the physician, for the Lord created him and let him not depart from thee, for his works are necessary." (Eccles., Chapter 38.)

I mention these two committees merely as examples. An equal amount of importance can be attached to each of the other eighteen. They are all vital cogs in our organization.

Aside from all this we have another problem which has assumed avalanche proportions and that is so-called "Socialized Medicine." It has been creeping gradually into this country in one form or another for several years back. But in the past year it has swept down upon us like a snowball rolling down the mountain side; we are in the valley below.

This problem had its inception in various forms, which at the time were quite benign. One might mention, for a starter, group examinations of college students or group examinations of factory workers by group physicians paid for this purpose.

Following on the heels of this we have preventive medicine as practised by local Boards of Health. Then came the free clinic or dispensary age, factory first aid rooms and then industrial surgery.

All of these systems seemed bent on destruction of the relationship between family physician and patient and free choice of physician became an almost forgotten memory.

The prime purpose of these plans was not intended to destroy our two cherished ideals. As a matter of fact, it was far from it. In the beginning and for a long time patients were referred back to their family physician for treatment. However, as time went on, the ties that bind were severed and our ideals became sacrificial victims to that great American god, "Economic Efficiency."

Then as time rolled on—came the thirties. The byword of the day became "unemployment." Soup kitchens came into existence over night. Factories closed, banks failed and cash money seemed doomed to become a memory.

Out of this chaos arose the Emergency Relief Association, a government project which realized medical care was a commodity which should be paid for. And for the first time the doctor was paid by the federal government for caring for the sick and the patient was allowed free choice of physician.

There were many flaws in this set-up and I do not intend going into that angle of it. The point I wish to stress is briefly this: Organized medicine was woefully negligent and lacking in its obligations and duties at the time. Had our Medical Societies been on the job and had taken a guiding hand, a coöperative spirit with intelligent leadership, the Emergency Relief set-up would have been a far different story. In spite of our lethargic lassitude free choice of physician was maintained.

Today, we are face to face with another crisis. Let's not get scared out of our wits. It isn't the end of the world. Let us keep a cool head about it all. We know the government is trying to institute socialized medicine. Only nine days ago, Governor Murphy held a conference for this purpose. The interest manifested by the doctors was intense. The facts presented, most of us were aware of. It was not news to hear that between fifty and sixty per cent of the people are medically indigent. We have known that for some time. The Governor did not speak of any plan by which these people could be cared for. He had only praise for the doctors who have been carrying this burden always. He voiced the sentiment that the medical profession should be paid for this work, and that the average income of the doctor is far below what he is worth. I sincerely hope that this is a reflection of the sentiment prevalent in our national capitol. He asked us to develop a plan whereby people of low incomes can get good medical care and the doctor get paid for it.

Plain spoken English such as that is, places a big burden on our doorstep. I think we should by all means show intelligent coöperation. Of all the people in this country, the medical profession should know how to run its own business and I think we do. Let us develop a suitable plan for it.

There are a number of doctors who think we should leave things as they are. They are looking forward to a betterment in national economic conditions. If this should come to pass, our problem would be solved. But we have spent eight long years looking toward that goal and it still isn't in sight.

Others advocate a system of sickness insurance. This can be set up as cash benefits to the patient such as is unemployment insurance, or the cash can be made payable directly to the doctor. The latter phase I personally do not approve of. Proponents of this cause claim it will function like the workmen's compensation law. The former method, it is claimed, would function similar to our present health and accident policies. There are many other plans and ideas of plans. You probably heard many of them yesterday.

With all the ideas that are prevalent, it seems as though we should be able to evolve a suitable plan which incorporates our own ideas for medical practice. You, the House of Delegates, are the leaders of the medical profession. You have been selected to sit in this body because of your knowledge of medical practice and of medical economics. Whatever is decided upon at this meeting will be for the good of all of us. Whether or not it agrees with your ideas or mine, we must all abide by it. When we leave this meeting and go back to our homes we must all preach the same doctrine. Any plan which suits the majority of this House of Delegates must of necessity suit the entire medical profession. (Applause)

The Speaker's address will be referred to the Reference Committee on Officers' Reports.

Dr. Riley resumed the chair.

THE SPEAKER: We shall now have the address of President Cook.

II. PRESIDENT'S ADDRESS

Dr. Henry Cook read the Address of the President.

DR. HENRY COOK: Your President appreciates the honor which has been conferred upon him during the past year in having the opportunity to serve you as your leader in a program of improving the quality of medical care and making it more available to those who need it. It has been my pleasure to visit many of your county societies and to have been honored by you. It has been my happy experience to have enlarged my acquaintance among the profession through the help which you have given me and the work which you have carried on. I can recall no instance in which the profession has not extended to me the kindest treatment. I have had the friendliest coöperation from your officers and your committeemen. I can not conceive of any organization working together in a more friendly spirit or with greater zeal in performing their duties and meeting the responsibilities placed upon them.

One year ago at Grand Rapids, the House of Delegates approved of a program. This program was a broad program of the improvement of medical care, both in the care of the sick and prevention of disease. It also took into consideration the matter of improvement of distribution of medical care. The committees and officers have worked with the State Health Department, through its Commissioner of Health, Dr. Gudakunst, who I can assure you is a real friend of the medical profession, in order that the programs of both the profession and the department of health may be coordinated. I am certain this relationship will continue.

It will be impossible to enumerate the work of all the committees. If I fail to mention the work of any one committee I hope they will not in any way consider that I do not appreciate the importance of their work or the efforts which they have put forth.

The delegates to the American Medical Association, without exception, have consulted with the Executive Committee of the Council endeavoring to represent to the American Medical Association the mind of the profession.

The Committee on Distribution of Medical Care sent out a questionnaire and I believe obtained information which will be of value to your Council and officers as well as the committees, to guide them in future policies.

The Cancer Committee has had numerous meetings and I feel has carried on a program of supreme importance to the public and of great help to the medical profession. I would urge more consideration by the profession of this extremely important problem.

The Preventive Medicine Committee, through its sub-committees, and through its own efforts, has had a number of meetings and has outlined plans, many of which have been put into effect, to further a program of preventive medicine jointly with the Health Department of the state in the interest of our people. Let me call your attention in the Hand Book to the work in developing an immunization schedule, which has been distributed to every member of the profession. Through its sub-committee on tuberculosis, it developed a program for the state ready to go ahead as soon as funds are available. They hope to, and I believe will be very helpful in improving the program of case finding and care of, as well as the elimination of tuberculosis. The sub-committee on syphilis control has done a fine piece of work.

The work done by the Committee on Post Graduate Medical Education is outstanding in this country and is an example to other states. Approximately one-third of our profession takes advantage of it annually.

You are all familiar with the work of the Public Relations Committee.

There is now in existence, in practically every county medical society in the state, a Committee on Maternal Health.

The Committee on Governmental Agencies has had numerous meetings with various individuals, the work of whom is of extreme importance to the profession. I believe that many friendships and acquaintances have been made by this committee. These contacts are of supreme importance to the profession. I believe that the work of this committee has made the medical profession more understood, and confidence in our state organization and its activities has been increased. The work of this committee should be carried on diligently in the future.

It is impossible to mention the work of all the committees. This work has cost money to the state society. However, I believe that it has been well spent and it would be false economy to restrict their activities. Various county medical societies have coöperated in this work, in fact as well as to have carried out programs in their own county in their own behalf, they have been of inestimable help to the state society. This work should be encouraged and enlarged. The success of the medical profession in their efforts to improve medical care and its distribution is largely dependent upon the activities of the county societies. Every effort should be made to interest the individual doctor of each county medical society in the efforts of the state and county societies. Our strength, as a profession, is dependent upon having a thoroughly informed profession. The officers of your state society, the committee members and each member of the House of Delegates must realize that he is a leader in the profession and especially in his own community, and he should exert every effort to meet his responsibility. Therefore, let me urge that you, the members of this House of Delegates, seriously study the problems which are discussed in this session and when it is over return to your county society, get together the officers and endeavor to explain to them the program of your state society as approved of by this House, urging them to coördinate the work of the county society with the state organization. After all, that is your duty.

Again, let me repeat, I appreciate the help and cooperation that I have had this year, and I take great satisfaction in the confidences that I have that you will give to Dr. Henry A. Luce, your incoming President, the help that he so much desires. I know

of no one in whom I have more confidence and respect.

Thank you. (Applause)

THE SPEAKER: Thank you, Dr. Cook. The President's Address will be referred to the Reference Committee on Officers' Reports.

We shall now have the address of the President-elect, Dr. Henry A. Luce.

III. PRESIDENT-ELECT'S ADDRESS

Dr. Luce read the Address of the President-Elect.

DR. HENRY A. LUCE: Mr. Speaker, Members of House of Delegates, Officers and Guests:

You are embarking on a meeting that bids promise of being a milestone in medical matters in the State of Michigan. Your President-elect believes in your ability to successfully meet and solve the problems that are presented to you. It is hoped that your decisions will be arrived at in a truly democratic manner in which each and everyone is allowed full privilege to say what he wants to say. Once having arrived at conclusions, your loyalty to the group will guarantee your support.

Your next year's President expects to make mistakes, but he will depend upon you to correct him and them. They will not be mistakes of the heart, but rather mistakes of judgment.

Your advice and counsel at this time is requested most earnestly at every opportunity and on every occasion. With your help and support, with your loyalty to organized medicine and with your basic elements of good citizenship which always characterizes a doctor of medicine, I pledge you my earnest and best efforts to interpret your wishes and to work for the highest ideals of our profession. (Applause)

THE SPEAKER: Thank you, Dr. Luce. Dr. Luce's address will be referred to the Reference Committee on Officers' Reports.

We shall now hear the Report of the Council. Dr. Urmston, Chairman of the Council.

IV. REPORT OF DELEGATES TO A.M.A.

(See page 1022)

V. ANNUAL REPORT OF THE COUNCIL

DR. P. R. URMSTON: Mr. Speaker and Members of the House of Delegates: As in the past, the report of the year's work is in your Handbook, but events happen so fast between the time of publication that the reports become obsolete.

I announced yesterday that we had a copy of the official proceedings of the A.M.A. House of Delegates. We were in error. It was simply a newspaper release. You will have the official report before the meeting is over, as we were just in communication with the A.M.A. and our stenographer took the report and it will soon be transcribed and copies furnished you.

Dr. Urmston read his supplementary report to that as published in the Handbook (Page 30) at the conclusion of which he said:

In our "Annual Report of The Council" published in the Delegates' Handbook, we devoted the final paragraph to "progress" of the Michigan State Medical Society. This progress can best be exemplified by the increases in membership during the past three short years. As of September 1, 1935, the membership was 3,468; as of the same date 1938, the membership was 4,017, an increase of 549 members! As of today, our MSMS membership is 4,043, this marking the first time that the total has gone over 4,000. This is remarkable in view of the raise in dues, and in the face of curtailed medical income due to the present recession. We believe that the individual member should realize that his small investment in MSMS membership is bringing in rich returns and extraordinary protection.

In our regular report (bottom of page 41 of Handbook), we advised that a brief on the legal status of chiropractors had been developed in the MSMS Executive Office. We are happy to report that the Michigan Attorney General, in an opinion dated August 23, 1938, ruled that the conclusions therein stated are correct. This opinion, together with the brief, will be published in the MSMS JOURNAL.

We are also gratified to report the recent opinion of the Michigan Attorney General dated August 3, 1938, to the effect that the practice of medicine by a corporation is illegal in this state. This illuminating ruling will also be published in the MSMS JOURNAL.

The Council realizes it is time to do something, so far as illegal practice by chiropractors and osteopaths is concerned, but a case carried up to the Supreme Court might leave us in the same status we are in at present. The only way in which the laws might be definitely clarified is through action by the Legislature. When you return, will you give that expression to your county societies and wait until the future, when we know that something definite can be done?

In order to accomplish this, we are not going to ask any raise in dues. In the Upper Peninsula they have stated they are willing to have an assessment. They want something done, and more can be accomplished by an assessment for such a fund than by the raising of dues.

We are striving in our efforts to give you protection and education. I thank you. (Applause)

THE SPEAKER: Dr. Urmston's address will be referred to the Reference Committee on Reports of the Council.

VI. REPORTS OF STANDING COMMITTEES

1. LEGISLATIVE COMMITTEE

Next we will have the reports of the various standing committees. First is the Legislative Committee, Dr. Christian, Chairman.

DR. L. G. CHRISTIAN: Mr. Speaker, the Report of the Legislative Committee is in the Handbook, and there is nothing further to report. I would like to have the report accepted as in the Handbook.

THE SPEAKER: Thank you, Dr. Christian. The Legislative Committee report will be referred to the Reference Committee on Reports of Standing Committees.

2. JOINT COMMITTEE ON HEALTH EDUCATION

Dr. Corbus will give the report of the Representatives to the Joint Committee on Health Education.

DR. B. R. CORBUS: The Chairman of the Joint Committee has no report other than that given in the Handbook.

THE SPEAKER: Thank you, Dr. Corbus. The report will be referred to the Reference Committee on Reports of Standing Committees.

3. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

We will now have the report of the Committee on Distribution of Medical Care. Dr. Pino.

DR. RALPH H. PINO: We present the material that is in the Handbook.

Dr. Hubbell presented the Plan from Kalamazoo for Reference Committee on Reports of Standing Committees.

Proposed Plan for Care of Medically Indigent

The principle objection to the present form of medical relief is its lack of efficiency, and the overlapping responsibilities of the various groups concerned. I can only speak of the condition as it exists in our own community, though I suppose with certain differences, similar situations obtain in other communities of the State.

There are three groups to be considered, the patients, the physicians, and the governmental units.

That patients should have free choice of a physician goes without saying. They should not, however, be required to draw their own conclusions regarding the nature of their illness, such as acute or chronic, hospital or non-hospital, nor should any other non-medical individual. I speak of the situation in our community, in which the ERA cares for acute cases at home or in the office, and the city cares for chronic cases and all hospitalization, and that sometimes a distinction is made by the patient or some ERA official. There should not then be a distinction in the type of case or the agency that cares for it.

In considering the physicians, one meets with some of the greatest difficulties. Certain physicians do not wish to care for indigents. That is their prerogative. There are others who wish to care for only certain ones, either, from knowledge of the family, or for certain medical or surgical conditions. There are others who would care for indigents, but not when the work interferes with their private patients. There is also the specialists to be considered, and what constitutes a specialty. In our community, with its open staff hospitals, the great majority of the physicians are general practitioners, who care for nearly all of their work, including surgery. So that in any successful plan for the care of the indigents, the whole local profession would have to coöperate, and each member would of necessity have to suppress his own desires and accept the responsibilities.

The third group is the governmental units, who pay the bills. We will assume for general purposes that all governmental units desire efficient, adequate and economical service; at least that is the principle governing their actions. I can only speak for our own community in which these principles are actually true, both as regards the City Commission, and the Board of Supervisors. It is axiomatic that any governmental unit that contributes money for any purpose, is going to insist on having something to say about its expenditure. This applies equally to Federal, State and local units, and any system of caring for the indigent ill, must recognize this.

I wish to submit then the following plan for the care of all individuals included in Section IV of the outline submitted by the State Medical Society, for local groups. It will be noticed that the groups listed contain those now administered by the State Welfare Department, the judges of Probate, the County Boards of Supervisors and City Commissions. I recognize that the plan is nothing new, but rather a combination of existing or proposed plans.

1. An Executive or Advisory Board consisting of 3 members, one appointed by the State Department of Welfare, or its successor, one by the Board of Supervisors, with the consent of the City Commission, in counties with a large city within the county, and one by the Board of Supervisors, with the consent of the Judge of Probate.

(The above assumes county unit plan of relief.) This Board to serve without compensation, to establish rules of procedure, to act in an advisory capacity, to be incorporated, to have final authority in the payment of bills, and any other powers necessary for efficient administration.

2. This Board to appoint a Director of Medical Relief, with the consent of the local medical society. Said director to be a physician, who is likewise an individual with administrative ability. He is to serve at the pleasure of the Board, and at a salary determined by them. The Director is to serve full time and have no other income from any source relating to the practice of medicine. The Director to employ a staff to carry on the work of the Department, such staff to include nurses, investigators and clerks.

The physicians of the community agree—and unless a majority agree, the plan is pointless—to do all the work of medical care. The patient may call the physician of choice, said physician to make the call if available. Frequent refusal to answer calls to be subject to investigation by the Director and recommendations of a disciplinary nature made to the Board. If the physician of choice is not available then any other choice is permitted. In the absence of any specific choice, the physicians to be called in rotation. If the patient needs hospitalization, the procedure of investigation of economic condition, residence, etc., to be cleared through the Director, with committment by the Director for the hospital bill. The Director is at all times permitted to ask consultation before hospitalization, if in his opinion the condition warrants. The Director is to likewise have the power to limit the stay in the hospital, and for any extended hospital stay, the responsibility of demonstrating the necessity rests with the physician in charge. Cases of reported illness, other than by physicians to be investigated by the nurses.

The fees paid to physicians and hospitals to be determined at the time of establishment of the plan, by the local medical society and the board, and any unforeseen fees determined by the Director and Board, commensurate with the established fee schedule. Necessity for specialists' services to be determined by the Director, and choice of specialists according to the wishes of the patient. Lists of specialists and their speciality to be determined by the Director and the local medical society.

The Director will also determine eligibility for committment to the University Hospital, should such be desired by the physicians. If it is desired a whole or part time physician may be employed for the care of institutionalized individuals, such as county infirmary, detention home, jail, etc. All others to be cared for by the private physicians.

The funds for the payment of physicians and hospital bills, and the administrative office, to be provided by the Federal, State and local governments as now. The Director, with the Board, to prepare each year, an estimate of the proposed expenditures for the following year. Any curtailment of income from any or all sources to be prorated among the fees paid. Those funds designated by any governmental agency for any particular purpose, to be so used.

Proper records and other pertinent data to be kept by the Director. Medical nursing, to the extent now provided by the Health Department or other agency to be provided by the Board. Care of contagious diseases, and where they exist, the operation of county and city hospitals, to be under the supervision of the Director.

There is to be no practice of medicine in the administrative office.

Weekly clinics for the treatment of venereal disease may be established at the discretion of the local Medical Society for reasons of economy or social status of the patients.

Accident calls from the hospitals, to be attended by the physicians in rotation according to some prearranged plan. Hospitalization of obstetrical cases according to some pre-arranged plan.

I realize the difficulties of this proposal. In the first place the Director is almost a medical dictator so far as the care of the indigents are concerned. There are few physicians of sufficient executive ability to properly act as a Director. The efficient operation of the plan would require the wholehearted coöperation of all the physicians in a community, and the practice of medicine is too individualistic to secure the coöperation of everyone. And yet the efficient, adequate and economical care of this group of people would require that such conditions be met. I don't imply that this is a perfect plan. I would expect many modifications. The plan incorporates some of my own ideas. But certainly the present day care of the indigent is in a chaotic condition, at least in our community. I realize that as set up the plan is open to political favoritism. The Director and Board would have to be of almost Divine inspiration, and yet I am convinced that in our community at least a similar plan would work. I recognize differences between County Boards of Supervisors and City Commissions that exists in some counties. We are thankful that such does not exist in ours. There is in general the fullest coöperation between elective and appointive officers The plan does not take into account the frailities of human beings, and yet I still think it would work. The alternative, of course, is what confronts us if some plan is not presented which has some reasonable assurance of successful operation. The issue will be forced upon us.

In such a spirit I submit this for your consideration.

4. PUBLIC RELATIONS COMMITTEE

Chairman L. F. Foster reported that the Report of the Public Relations Committee was complete as in the Handbook.

5. MEDICO-LEGAL COMMITTEE

Dr. Stapleton reported for Chairman McLean that the Report of the Medico-Legal Committee was complete as printed in the Handbook.

6. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

Dr. Cummings, reporting for Chairman Bruce on the Committee on Postgraduate Medical Education, drew attention to the report in the Handbook, and added the supplemental report:

6 (a). ADVISORY COMMITTEE ON POSTGRADUATE EDUCATION

Supplemental Report

A meeting of this Committee was held at twelve o'clock, noon, on September 2, 1938, at the Wayne County Medical Society Building, Detroit, Michigan.

Members in attendance: Drs. A. P. Biddle, B. R. Corbus, H. H. Cummings, C. T. Ekelund, W. B. Fillinger, D. W. Gudakunst, G. A. Kamperman, R. R. Smith, D. I. Sugar, and James D. Bruce, Chairman. Dr. Henry Luce and Dr. Henry Carstens also were present.

Dr. Bruce stated that the purpose of the meeting was to obtain the opinion of the Committee relative to the qualifications for certification of physicians attending the extramural courses for practitioners. He reviewed briefly the plan that had been developed. This plan of continuing medical education attempts to cover the recent advancements in medicine and to present those subjects of interest and value to the practitioner of medicine. Because of the numerous fields to be covered and the subjects to be presented, it had been found necessary to extend the courses over a four-year period.

The chairman presented a list of names for certification as instructed by the House of Delegates at the Annual Meeting of the Michigan State Medical Society, held in Grand Rapids on September 27, 1937. All these candidates for certification have attended 50 per cent or more of the extramural lectures given over the past four years, or have attended the composite courses given each spring in Detroit over a period of four years, or have given satisfactory evidence of having taken comparable postgraduate work either in this state or elsewhere.

The chairman also presented a list of names of those who have attended in excess of 50 per cent of the total number of hours included in the four-year extramural program, but which was completed within three years. The Committee felt it desirable to continue the requirement of four-year attendance on the extramural program, and the following resolution was unanimously passed:

"That the Committee on Postgraduate Medical Education recommends to the Executive Committee of the Council that only physicians who have met the requirements for certifications, as set up by the House of Delegates, be presented with Certificates at the annual meeting of the Michigan State Medical Society."

The list which included the four-year candidates was then approved, pending final action by the Executive Committee of the Council.

It was moved by Dr. Kamperman, seconded by Dr. Smith, and passed by the Committee, "that this Committee go on record as recommending to the House of Delegates at its next session that physicians, in order to receive credit for postgraduate work, be required to attend the courses as recommended by the House of Delegates for four consecutive years, or do comparable work, except in cases of absence from the State, sickness or other reasonable excuse, and that the time limit for completion of the work be not over six years.

The chairman then presented a plan for the recognition of medical activities outside the courses of formal instruction as set up by the House of Delegates. All agreed that such a plan would help stimulate greater interest in educational work and serve to integrate county and other society groups with a central plan of postgraduate education. This tentative plan is based on a unit system of credits, 15 units in any one year being required for qualification for certification for Associate Fellowship.

1.	Attendance at County Society meetings (60 to 75 per cent?)	2 units
2.	Attendance at State Society meeting.	1 unit
3.	Attendance at American Medical Association meeting.	1 unit
4.	Attendance at Postgraduate Conference.	1 unit
5.	Attendance at a recognized National Meeting.	1 unit
6.	Attendance on 75 per cent or more of the Extramural Program	15 units
7.	Attendance on yearly composite course.	15 units
8.	Attendance on intensive special courses in Michigan Program. (each)	5 units
9.	Attendance on formal special courses in recognized specialty to which the attendant limits himself.	15 units
10.	Membership in and attendance on approved educational societies and activities.	1-5 units

The presentation of Certificates of Fellowship is recommended not only to those who have earned them by complying with requirements set up by the House of Delegates from time to time, but also to those engaged in teaching and research activities in our medical schools, and those making contributions to medical advance through membership in and attendance on hospital staff conferences.

It is believed that this form of recognition will make the possession of certification more keenly to be desired by our membership who aspire to recognition for acceptable educational activities, regardless of their position and practice, and assist in preserving those democratic ideals so long distinguishing the activities of this Society.

In order that there be at all times an under-

standing of the objectives and activities of all committees of the Society having to do with health education, it is recommended that the chairmen of the following committees be made members, or ex-officio members, of the Advisory Committee on Postgraduate Education: The Preventive Medicine Committee, Cancer Committee, Radio Committee, Maternal Health Committee, Mental Hygiene Committee, and Joint Committee on Health Education.

At the Grand Rapids meeting one year ago, the chairman of this Committee recommended efforts on the part of the Society for the establishment of an Endowment Fund for postgraduate education. The executives of the Society have discussed this matter at considerable length with the chairman of this Committee, and it is gratifying to report that substantial progress is being made toward this objective.

7. CANCER COMMITTEE

The Report of the Cancer Committee was submitted as printed in the Handbook.

8. PREVENTIVE MEDICINE COMMITTEE

The Report of the Preventive Medicine Committee was submitted as printed in the Handbook.

9. ETHICS COMMITTEE

The Report of the Committee on Ethics was submitted as printed in the Handbook, by Dr. L. C. Harvie, who stated that Dr. Porter's diplomacy has smoothed rough spots and made friends.

All reports of Standing Committees were referred to the Reference Committee on Reports of Standing Committees.

THE SPEAKER: I want to thank Dr. Clinton, the Chairman of the Golf Committee, for his work, even though the tournament could not be held.

DR. ROBB: I move that we take up the reports of the Special Committees from the afternoon's program.

The motion was seconded by Dr. Humphrey and carried.

VII. REPORTS OF SPECIAL COMMITTEES

1. MATERNAL HEALTH COMMITTEE

Dr. H. W. Wiley reported for Dr. Campbell, the Chairman, that the Maternal Health Committee's report was complete as in the Handbook.

2. CONTACT COMMITTEE TO GOVERNMENTAL AGENCIES

DR. HENRY COOK: Mr. Speaker, the full report of the Committee is published in the Handbook.

3. MEMBERSHIP COMMITTEE

DR. M. H. HOFFMANN: Mr. Speaker, the Report of the Membership Committee is found in the Handbook.

4. LIAISON COMMITTEE WITH THE HOSPITAL ASSOCIATION

DR. T. K. GRUBER: Mr. Speaker, I should like to present the report by title, as printed in the Handbook, page 116.

5. RADIO COMMITTEE

DR. C. F. SNAPP: I should like to submit the report that is published in the Handbook.

6. ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

DR. H. W. WILEY: I believe that report is complete as printed in the Handbook.

7. COMMITTEE ON OCCUPATIONAL DISEASES AND INDUSTRIAL HYGIENE

DR. HENRY COOK: I should like to state it is all in the Handbook as far as the Committee is concerned. I have been informed that the same tendency is now taking place in Michigan as in other states, that the state institutions are tending to become the consultants for occupational disease work.

However, I will say that my understanding is that the men in the institutions are charging adequate fees and they are objecting to it, thinking they should get it done for nothing. They are right in the middle of it now, and there is possibly another opportunity there to straighten out the situation. I might say that the men who are in the institutions do not feel they should do that work, and it is in the interest of the profession that they should recognize our rights as well as those of the public.

8. COMMITTEE ON HEALTH LEAGUE

DR. L. R. CHRISTIAN: The Michigan Health League was organized by the physicians, dentists, druggists, and nurses. We had a few meetings, and finally came to the point where the League was about to be incorporated, on June 22nd. Since that time some of us have been just a little irritated that we have had no further meetings.

We believe that this organization can be made a great agent for good. We are hoping that during the next year every member of the various organizations will become an active member of the Health League.

As a similar League has worked out in other states, particularly California, Washington, and Arizona, it has been a great aid to the Legislative Committee of the Medical Society and of the Dental Society of those states, preventing a lot of bad health legislation.

9. LIAISON COMMITTEE WITH STATE BAR OF MICHIGAN

This report appears complete in the Handbook.

10. MENTAL HYGIENE COMMITTEE

DR. M. H. HOFFMANN: Mr. Speaker, the Report of the Mental Hygiene Committee is found complete in the Handbook.

11. ADVISORY COMMITTEE TO PAROLE COMMISSION

12. IODIZED SALT COMMITTEE

These two reports, and all reports of Special Committees, were referred to the Reference Committee on Reports of Special Committees.

DR. J. M. ROBB: I believe next year each chairman of a committee should be asked to present a short abstract on the floor to the delegates. A little summary will clarify our minds as to just what the Committees have accomplished and what their problems have been.

THE SPEAKER: Thank you, Dr. Robb. If I am Speaker next year, I will do that.

If there are any supplementary reports to come in on these special committees this afternoon, they will be heard, because some of these chairmen were not present, even though their reports are printed in the Handbook.

Now, our afternoon session is called for 3:00 p. m. sharp, but it will be possible to start the session at 2:30.

DR. ROBB: I move we recess.

The motion was seconded by Dr. H. W. Plaggemeyer and carried.

The meeting recessed at ten forty-five o'clock.

Monday Afternoon Session

September 19, 1938

The meeting was called to order at two fifty-five o'clock, Dr. Riley, the Speaker, presiding.

THE SPEAKER: We will now open the second session of this meeting.

VIII. REPORTS OF REFERENCE COMMITTEES

VIII (1). REFERENCE COMMITTEE ON OFFICERS' REPORTS (I, II, III)

The first thing we will take up is the Reports of the Reference Committees, and we will start with Dr. O'Donnell, Chairman of the Reference Committee on Officers' Reports.

Dr. F. J. O'Donnell read the Report of the Reference Committee on Officers' Reports:

Your committee on Officers' Reports, consisting of Doctors Harkness, Day, Catherwood, Cooksey, Snapp and myself, met immediately after the adjournment of this morning's session and we wish to announce that this is about the only reference committee whose material is not printed in the blue handbook for delegates, thereby making our committee meeting very lengthy and difficult.

This may be out of order and perhaps out of the scope of this committee, but we all are in hearty accord with the suggestion of Dr. Robb that a brief summary be given on the floor in the Reports of Committees rather than just referring to the handbook in its entirety.

The reports of the Speaker, President and President-elect were all given this morning and this committee received and scrutinized them in detail and we wish to commend the Speaker, President, and President-elect on the cleanness, conciseness and brevity of their reports.

There being no specific recommendations contained therein, we approve them in their entirety.

Committee on Officers' Reports: LUTHER W. DAY, M.D.; F. J. O'DONNELL, M.D.; A. E. CATHERWOOD, M.D.; CARL SNAPP, M.D.

DR. O'DONNELL: I move this report be accepted.

The motion was seconded by Dr. R. M. McKean of Wayne and carried.

VIII (2). REFERENCE COMMITTEE ON REPORTS OF SPECIAL COMMITTEES

THE SPEAKER: We will now hear from Dr. Umphrey, the Chairman of the Reference Committee, on Reports of Special Committees.

VIII (2a). REFERENCE COMMITTEE ON WOMAN'S AUXILIARY [VII (6)]

Dr. C. E. Umphrey read the Report of his Reference Committee on the Annual Report of the Woman's Auxiliary Committee:

In addition to the report as outlined in the Handbook on page 96, Doctor Urmston appeared before the Committee and reported on several resolutions that were approved by The Council. It was Doctor Urmston's further suggestion that more auxiliary units be promoted through contact by the members of or a committee of members of the State Medical Society. A further suggestion was that a definite program be offered to the Council of the Woman's Auxiliary.

The Committee further offers the following three suggestions: First, the adoption of the slogan "Every member, get a member"; Second, a canvass of the clubs of Michigan with the object of greater representation in lay organizations; Third, the consideration of the possibility of representation in the State and National Congress.

The Committee wishes to recommend the report and recommendations as outlined for adoption. I so move.

DR. UMPHREY: I move the adoption of the report.

The motion was seconded by Dr. W. R. Torgerson and carried.

VIII (2b). REFERENCE COMMITTEE ON RADIO COMMITTEE [VII (5)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Radio Committee including the motion for the adoption of the report.

Your Committee has studied the activities of the Radio Committee as outlined in the Handbook and wishes to add its word of commendation for the splendid programs as outlined. If we were to make a suggestion at this time, it would be to the effect that more time be given in explanation of the medical facilities which aid our citizens in receiving more complete medical care. We believe this type of program would be especially appropriate now because of the numerous changes contemplated. Your Committee recommends the adoption of this report. Mr. Speaker, I so move.

The motion was seconded by Dr. C. E. Simpson and carried.

VIII (2c). REFERENCE COMMITTEE ON MATERNAL HEALTH [VII (1)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Committee on Maternal Health, including the motion for the adoption of the report.

In this report your Committee wishes to call your attention to paragraph four. We wish to commend the committee on withholding its approval of the proposal herein stated until the majority of physicians in the Northern Peninsula are in favor of the plan.

The Committee wishes to commend Doctor Campbell and his committee for their report as outlined in the Handbook as well as the supplementary report delivered before the House of Delegates this afternoon.

I move the adoption of these reports.

The motion was seconded by Dr. P. W. Kniskern and carried.

VIII (2d). REFERENCE COMMITTEE ON GOVERNMENTAL CONTACT COMMITTEE [VII (2)]

Dr. Umphrey read the Report of his Committee on the Annual Report of Contact Committee to Governmental Agencies, including the motion for adoption.

Your Committee is aware of the extent of the accomplishments of this committee and heartily agee that these activities should be continued.

I, therefore, move the adoption of this report.

The motion was seconded by Dr. C. F. Brunk and carried.

VIII (2e). REFERENCE COMMITTEE ON MENTAL HYGIENE [VII (10)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Mental Hygiene Committee including the motion for adoption.

In this report the Committee has confined its endeavor to the scientific approach to subjects which deal with mental health. We would recommend in paragraph three that the word *publications* be changed to manuscripts, and that there be inserted after the word *reviewed* the phrase "at the discretion of the Editor." With these minor corrections, I wish to move the adoption of this report.

DR. UMPHREY: We recommend in paragraph three that the word "publications" be changed to "manuscripts," and that there be inserted after the word "reviewed" the phrase "at the discretion of the Editor."

THE SPEAKER: It has been moved that this report be accepted and adopted. Is there any second to it?

The motion was seconded by Dr. Andrew P. Biddle and carried.

VIII (2f). REFERENCE COMMITTEE ON OCCUPATIONAL DISEASES [VII (7)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Advisory Committee on Occupational Diseases including the motion for adoption.

Your Committee feels that the work of this committee is important now and will be in the near-future, and that it should be continued for another year. I, therefore, move the adoption of this report.

The motion was seconded by Dr. Snapp of Kent and carried.

VIII (2g). REFERENCE COMMITTEE ON PAROLE COMMISSION [VII (11)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Advisory Committee to the Parole Commission including the motion for the adoption of the report.

In this report, your Committee would especially call your attention to the recommendations one of which is that at least one of the five commissioners of the Michigan Department of Corrections might well be a Doctor of Medicine. We believe the recommendations are excellent and that the work of this committee should be continued. I therefore, move the adoption of this report.

The motion was seconded by Dr. C. E. Dutchess and carried.

VIII (2h). REFERENCE COMMITTEE ON MEMBERSHIP [VII (3)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Membership Committee including the motion for the adoption of the report.

Your Committee wishes to compliment the first Membership Committee of our organization on its accomplishments during the past year. We would especially call your attention to the recommendations as outlined on page 114 of the blue book. In regard to these recommendations, we recommend that the succeeding committee view carefully the first recommendation, with the possibility of eliminating any controversial procedures.

With this suggestion, I move the adoption of this report.

The motion was seconded by Dr. Hubbell.

THE SPEAKER: This first recommendation is:

"That, if possible, some activity be initiated by the State Society, to make public the rules of the special societies, and a statement as to the number of members of that Society, possibly through publicity in the JOURNAL."

Do you want to state your recommendation again?

DR. UMPHREY: We recommend that the succeeding committee view carefully the first recommendation, with the possibility of eliminating any controversial procedures.

The motion was carried.

VIII (2i). REFERENCE COMMITTEE ON MICHIGAN HEALTH LEAGUE [VII (8)]

Dr. Umphrey read the Report of his Committee on the Annual Report of Representatives to Michigan Health League including the motion for adoption of the report.

Doctor Christian met with your Committee and discussed at considerable length the possibilities of a Michigan Health League. Your Committee feels that there is a large field of endeavor and that the committee should formulate a program and make every effort to carry it to completion.

With this suggestion, I move the adoption of this report.

The motion was seconded by Dr. William J. Stapleton and carried.

VIII (2j). REFERENCE COMMITTEE ON HOSPITAL LIAISON [VII (4)]

Dr. Umphrey read the Report on the Liaison Committee with the Michigan Hospital Association including the motion for the adoption of the report.

Your Committee wishes to pay tribute to Doctor Gruber and his committee for the tremendous amount of work they have done. It is the desire of the Liaison Committee with the Michigan Hospital Association that your attention be called to an insertion in paragraph three, page 117, of the Handbook. After the word "disorders" should be inserted the following "after commitment."

The Reference Committee wishes the adoption of this report and recommends further detailed study by the Standing Committee on the Distribution of Medical Care.

Mr. Speaker, I so move.

The motion was seconded by Dr. W. D. Barrett and carried.

VIII (2k). REFERENCE COMMITTEE ON BAR LIAISON [VII (9)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Liaison Committee to the State Bar of Michigan, including the motion for adoption.

In view of the limited work done by this committee and inasmuch as no member of said committee was present to report, recommend the adoption of the report as published on page 120 of the Handbook.

Mr. Speaker, I so move.

The motion was seconded by several and carried.

VIII (2-l). REFERENCE COMMITTEE ON IODIZED SALT [VII (12)]

Dr. Umphrey read the Report of his Committee on the Annual Report of Iodized Salt Committee.

Inasmuch as the work of this committee appears to be incomplete, we wish the adoption of the report and the continuance of the committee for another year.

Mr. Speaker, I so move.

The motion was seconded by Dr. Alexander W. Blain and carried.

DR. UMPHREY: Mr. Speaker, I wish to move the adoption of the report *in toto*.

The motion was seconded by Dr. A. V. Wenger and carried.

THE SPEAKER: Thank you, Dr. Umphrey.

VIII (3). REFERENCE COMMITTEE ON REPORTS OF THE COUNCIL (V)

I will call on Dr. Brasie for the Report of the Reference Committee on Reports of the Council.

Dr. D. R. Brasie read that portion of the Report of the Reference Committee on Reports of the Council which referred to Membership.

Your Committee submits the following report and recommendations:

Membership

The Society is to be congratulated on the success of the efforts of the Membership Committee; the present total of 4,043 being the greatest in history of the Society and this in a time of depression.

The Committee endorses the recommendation of the Council in regard to constitutional change in Article III, Section 1, to insure that active membership in a County Medical Society shall include active membership in the State Society, that the present section be amended by adding after the words "have been paid" the following sentence: "Membership in a County Medical Society on a basis not including membership in the Michigan State Medical Society is not recognized."

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of that part of the report.

DR. T. K. GRUBER (Eloise): Is this a motion that the amendment to the Constitution and By-Laws be adopted?

THE SPEAKER: This is not an amendment to the Constitution and By-Laws. We are just recommending that an amendment be created sometime in the future.

The motion was seconded and carried.

Dr. Brasie read the part of the Report under the heading THE JOURNAL.

The Journal

The Council recommends an increase in the use of Professional cards in the JOURNAL. This is approved.

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of this report.

The motion was seconded by Dr. Barrett and carried.

Dr. Brasie read the part of the Report under "Contacts with Governmental Agencies."

Contacts With Governmental Agencies

The Committee commends the Council on its stand taken in the matter of physicians in State Institutions under the Civil Service Commission being required to care for State employees, but wishes clarification of the point "Receiving payment in kind" and recommends aggressive follow-up of this situation.

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of this report.

The motion was seconded by Dr. H. W. Wiley and carried.

Dr. Brasie read that part of the Report entitled, "Contacts with Unofficial Groups."

Contacts With Unofficial Groups

The Committee asks at this time for a statement from a Special Committee of the Council as to why a more "wholesome coöperation" from the State Board of Nurses pertaining to the requirements for Nurses Training School was not received.

THE SPEAKER: Do you want to amplify that?

DR. URMSTON: Mr. Speaker, a committee was appointed to confer with the Nurses' Board of Registration and a meeting was held. At that meeting the group asked for further conference. That meeting was never held. Your committee did everything in its power to act on your wishes, but when the Nurses' Board of Registration and the hospitals said, "It is of no interest to us," that is all we could do. That is why it was never clarified.

DR. HENRY COOK: The problems that were discussed at that meeting, I think, should be somewhat clarified. There are two problems involved in the matter of running an institution of nurses. One is the educational side, and the other is the side of service to those who desire nursing. In the efforts that were brought forward by the medical group, desiring that something be done about furnishing nursing care on certain recommended bases of lowered costs for medical service in various institutions, right away the problem of lowering of the standard of training of nurses was brought forward. I think that is the point upon which each of these negotiations met obstacles. There was a meeting to be held in Lansing. There were certain doctors who were interested at that time, who brought the question up before the House of Delegates—Dr. Oakes, Dr. Arnold, and, I think, Dr. Greene and Dr. King. The second meeting was held, but Dr. Oakes was the only physician who attended.

Dr. Brasie read that part of the Report under the heading "Organization."

Organization

The Council recommends that your Committee endorses:

(1) The continuation of two secretaries conferences each year, one on the occasion of the annual meeting and the other in mid-winter. Your committee commends the innovation of the Secretaries Conference of the U.P. Societies.

(2) Merger of the Delta and Schoolcraft County Medical Societies.

(3) Partition of the present Thirteenth Councilor District as requested by the County Medical Societies comprising the same.

(4) The re-numbering of the Seventeenth Councilor District in the Upper Peninsula to the Thirteenth Councilor District.

DR. BRASIE: Mr. Speaker, I recommend the acceptance and adoption of this report.

The motion was seconded by Dr. Clinton.

THE SPEAKER: Is there any discussion on this matter? I don't know whether you all understand it or not, but the Thirteenth Councilor District is to be divided and the eastern half included in the Tenth District and the western half in the Ninth. In the Upper Peninsula, two county medical societies, Delta and Schoolcraft, are being consolidated.

The motion was carried.

Dr. Brasie read the recommendation on "Committees."

Committees

1. The Council recommends that no aggressive legislation be sought by the M.S.M.S. in 1939. This is endorsed.

2. The Committee approves the action of the Council that medical defense be continued in this state but that certain changes be made to make it more efficient as presented in the concrete recommendations of the Medical Legal Survey Committee.

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of this report.

The motion was seconded by Dr. L. W. Switzer and carried.

Dr. Brasie read the recommendation on "Emergencies."

Emergencies

Your Committee specifically calls to your attention the following paragraphs in the report of the Council on pages 41 and 42 of the Handbook, as follows:

"Contacts were made with our two U. S. Senators and seventeen Congressmen in Washington on a number of important medical problems before Congress. Friends in Congress were made, especially Congressman Paul W. Shafer of Battle Creek, who championed Medicine in Congress on two memorable occasions."

"In view of the multiplicity and increase of our general problems, the medical profession must sustain its activity and must look for an increase in civic endeavor and quasi-public work, as part of its important and ever-increasing functions."

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of this report.

The motion was seconded by Dr. R. L. Finch and carried.

Dr. Brasie read the recommendation on "New Activities."

New Activities

The Committee endorses the Council's recommendation to its A.M.A. delegates that they use their influence to secure a Public Relations Bureau in the A.M.A.

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of this report.

The motion was seconded by Dr. Dutchess and carried.

DR. BRASIE: Your Committee heartily commends the untiring efforts of the Council, its Executive Committee, the Officers of the State Society, and the numerous committees as evidenced by the many meetings listed in The Council report, on pages 38 and 39 of the Handbook.

Mr. Speaker, I move the acceptance and adoption of this report as a whole.

The motion was seconded by Dr. E. D. Spalding.

THE SPEAKER: It has been moved and seconded that this report be accepted as a whole. Is there any more discussion now?

The motion was carried.

THE SPEAKER: Thank you, Dr. Brasie.

Will the President-Elect please come forward? (Applause.)

Dr. Luce is to give us a report for the Delegates of the American Medical Association.

IV. REPORT OF DELEGATES TO A.M.A.

DR. HENRY A. LUCE: Mr. Speaker, Members of the House of Delegates, and Guests: I hold in my hand a paper which represents all of the important action that was taken at Chicago last Friday and Saturday. We telephoned Dr. West and he agreed to the arrangement that he would get the final copy with all the corrections that had been made in it and telephone that to a stenotype operator this morning. That was done, transcribed, and is now ready for distribution. This constitutes the supplementary report of the members who composed your delegates to that special session. (The report was distributed.)

Report of the Summarizing Committee of the House of Delegates of the American Medical Association

Since it is evident that the physicians of this nation as represented by the members of this House of Delegates convened in special session favor definite and decisive action *now,* your committee submits the following for your approval:

Recommendation I. Expansion of Public Health Service

1. The establishment of a federal department of health, with a secretary who shall be a doctor of medicine and a member of the President's Cabinet.

2. The general principles outlined by the technical committee for the expansion of public health and maternal and child health services are approved, and the American Medical Association definitely seeks to coöperate in developing efficient and economical ways and means of putting into effect this recommendation.

Any expenditure made for the expansion of public health and maternal and child health services should not include the treatment of disease, except insofar as this cannot be successfully accomplished through the private practitioner.

Recommendation II. Expansion of Hospital Facilities

1. We favor the expansion of general hospital facilities where need exists. The hospital situation would indicate that there is at present greater need for the use of existing facilities than for additional hospitals. We heartily favor the approval of the recommendation of the technical committee pertaining to the use of existing hospital facilities. The stability and efficiency of many existing church and voluntary hospitals could be assured by payment to them of the cost of the necessary hospitalization of the medically indigent.

Recommendation III. Medical Care for the Medically Needy

1. We advocate recognition of the principle that the complete medical care of the indigent is a responsibility of the community medical and allied professions, and that such care should be organized by local government units and supported by tax funds. Since the indigent now constitute a large group in the population, we recognize that the necessity for state aid for medical care may arise in poorer communities and the federal government may need to provide funds when the state is unable to meet these emergencies. Reports of the Bureau of Census of the U. S. Public Health Service and of life insurance companies show that great progress has been made in the United States in the reduction of morbidity and mortality among all classes of people. This reflects the good quality of medical care now provided. We wish to see continued and improved the methods and practices which have brought us to this present high plane. We wish to see established well-coördinated programs in the various states in the nation for improvement of food, housing, and the other environmental conditions which have the greatest influence on the health of our citizens. We wish also to see established a definite and far-reaching public health program for the education and information of all the people, in order that they may take advantage of the present medical service available in this country. In the days of the vanishing support of philanthropy, the medical profession as a whole will welcome the appropriation of funds to provide medical care for the medically needy, providing first, that the public welfare administration procedures are simplified and coördinated; and second, that the provision of medical services is arranged by responsible, local public officials, in coöperation with the local medical profession and its allied groups. We feel that in each state a system should be developed to meet the recommendation of the National Health Conference, in conformity with its suggestion that "the rôle of the federal government should be principally that of giving financial and technical aid to states in their development of sound programs through procedures largely of their own choice."

Recommendation IV. General Program of Medical Care

We approve the principle of hospital service insurance which is being widely adopted throughout the country. It is capable of great expansion along sound lines and we particularly recommend it as a community project. Experience in the operation of hospital service insurance or group hospitalization plans has demonstrated that the plans should confine themselves to provision of hospital facilities and should not include any type of medical care. We recognize that health needs and means to supply needs vary throughout the United States. Studies indicate that the health needs are not identical in different localities, but that they usually depend on local conditions and therefore are primarily local problems.

We therefore encourage county or district medical societies, with the approval of the state medical society of which each is a component part, to develop appropriate means to meet their local requirements. In addition to insurance for hospitalization, we believe it is practicable to develop cash indemnity insurance plans to cover in whole or in part the costs of emergency or prolonged illness. Agencies set up to provide such insurance should comply with state statutes and regulations, to insure their soundness and financial responsibility, and have the approval of the county and state medical societies under which they operate.

We are not willing to foster any system of compulsory health insurance. We are convinced that it is a complicated bureaucratic system which has no place in a democratic state. It will undoubtedly set up a far-reaching tax system with great increase in the cost of government that would lend itself to political control and manipulation, there is no doubt.

We recognize the soundness of the principles of workmen's compensation laws and recommend the expansion of such legislation to provide for meeting the cost of illness sustained as a result of employment in industry. We repeat our conviction that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. Further development of group hospitaliza-

tion and establishment of insurance plans on the indemnity principle to cover the cost of illness will assist in solution of these problems.

Recommendation V. Sickness Insurance Against Loss of Wages During Sickness

In essence, the recommendation deals with compensation of loss of wages during sickness. We unreservedly endorse this principle, as it has distinct influence toward recovery and tends to reduce permanent disability. It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness and of recovery, which function should be performed by qualified medical employees of the dispensing agent.

To facilitate the accomplishment of these objectives, we recommend that a committee of not more than seven physicians representative of the practicing profession, under the Chairmanship of Dr. Irvin Abell, President of the American Medical Association, be appointed by the Speaker to confer and consult with the proper Federal representatives relative to the proposed National Health Program.

The above report was unanimously adopted by the House of Delegates of the A.M.A.

DR. LUCE: That concludes the report. Thank you.

THE SPEAKER: Will you read the report? It isn't long.

Dr. Luce read the Report of the Summarizing Committee of the House of Delegates of the American Medical Association called in Special Session to consider the National Health Program, Chicago, September 16-17, 1938, during the reading of which the following interpolations were made:

1. Page 1: DR. ANDREW P. BIDDLE: I should like to ask if this interferes with the organized Public Health Service.

DR. LUCE: My interpretation of that line is that which has been stated heretofore several times, that the medical profession would like a member of the President's Cabinet to be a doctor of medicine who will be in a position to coöperate with organized medicine.

DR. R. C. PERKINS: I believe this question was asked yesterday also: Would that particular set-up be in any way directly connected with the present United States Public Health Service?

DR. LUCE: I believe it is a separate and distinct new cabinet position. Remember that the A.M.A. House of Delegates couldn't go into the hair-splitting details connected with the problems that were brought up. They made a general statement as a guide of the conduct of organized medicine. There may be some things that you would like to see in here. This committee tried to leave that open enough so that whatever you wanted to put in or interpret in your own individual localities could be done.

* * *

2. Page 1: Unless you want to ask a question, I will volunteer this information. It was brought out that time that they had the syphilis program in the City of Chicago. In order to coöperate definitely with the drive toward the eradication of syphilis it was necessary to hire twenty-five doctors to serve certain portions of the population of Chicago.

* * *

3. Page 2: Again I would like to give you that definition of the medical indigent which we gave yesterday. It is not on the piece of paper which you have, but will probably come in the *Journal of the American Medical Association* and probably in the Michigan State Medical Society JOURNAL. This is the important definition that was adopted by the House of Delegates:

"A person is medically indigent when he is unable, in the place in which he resides, through his own resources, to provide himself and his dependents with the proper medical, dental, nursing, and hospital care, together with pharmaceutical and therapeutic appliances, without depriving himself or his dependents of the necessary food, clothing, shelter and similar necessities of life, as determined by the local authorities charged with the duty of disbursing relief for the medically indigent."

Is there any question?

* * *

4. Page 2: By a community project, we mean that the doctors enter into it, the hospitals enter into it, the Boards of Commerce enter into it, the Community Fund enters into it, the Parent-Teacher Association enters into it, and that it can be sold to those who need it.

The cost of insurance, if it is sold by agents, if my recollection serves me correctly, runs anywhere from 35 to 40 per cent more than the cost of a project that is sponsored by the community interests. There is practically no sales proposition because every doctor becomes an agent for it, every social worker becomes an agent for it, and every community service becomes an agent for it, and the expense of sales is largely taken care of. For this particular provision, credit can be given to the State of Michigan.

* * *

In your papers that you have on hand, in the second paragraph, under Recommendation IV, the second sentence, beginning, "In addition to insurance for hospitalization, we believe it is practical to develop," insert the word "cash" at that point—"cash indemnity insurance plans."

* * *

THE SPEAKER: Are there any questions you would like to ask Dr. Luce now?

DR. L. W. DAY: In Recommendation V there is no allusion to disability due to accident. In the realm of insurance there is quite a difference in disability due to sickness and disability due to accident.

DR. LUCE: You can't live near Ann Arbor without acquiring some of the erudition and culture that exist there. Dr. Cummings has called my attention to the fact that there is a word that is misused here, the second to the last word, under Recommendation V. It should be "disbursing" not dispersing.

Dr. Day's question, I think, is very well taken on disability due to accident. If I understand it correctly, in essence the recommendation deals with loss of wages during sickness. That is the particular part. He informs me that the insurance companies recognize a difference between sickness and accident. Is that correct?

DR. DAY: That is correct.

DR. LUCE: I am of the opinion that it was the intention of the committee to include the word "accident" in there, although I doubt if it was put in. Perhaps that can be made an addition at some subsequent time.

THE SPEAKER: Are there any other questions?

DR. R. C. PERKINS: In connection with the words "cash indemnity insurance plans to cover in whole or in part the costs of emergency or prolonged illness," in this discussion was there any embodiment therein of the plans whereby the physician would be reimbursed for the services which he rendered in these particular cases?

It may sound commercial, but it is in the interest of economic problems as they affect the physician and not entirely commercial. Cash indemnities are at present paid by insurance companies to the recipients of injuries, for instance, in automobile

accidents, but very often a physician gets no part of that indemnity.

DR. LUCE: As I said at the outset, all of these principles can be elaborated upon. We have frequently stated throughout that arrangements and details of different localities growing out of this must be made with the consent and approval of the local county or state medical society.

May I ask Dr. Leland if he would like to add a word to that?

DR. R. G. LELAND: The committees did consider and discuss methods by which the physicians could receive pay under a plan developed as recommended under Recommendation IV, "cash indemnity insurance."

It must be remembered that at the present time there is a difference in the different states, and there are, in operation in a number of states, methods by which the physician, knowing a patient has some form of insurance, may take steps to safeguard the payment on the cash which is due the patient, either to himself or to the hospital, by some form of assignment clause or other method.

It was thought, however, by the committee, as I recall it, that it would be better at this time for the main committee to confine itself to principles and to permit the state and county medical societies to consider appropriate measures pertaining to the payment in the plans which they develop in their own jurisdiction.

DR. HENRY COOK: Mr. Speaker, I think in the discussion before writing in the word "cash" benefits, the point was brought out that that eliminates the possibility of the employment of a physician to render a service. By putting in "cash" benefits it gives the one who carries the policy more liberty to choose his own physician and have the money available to pay him.

I think that was written in that way because of the experience some of the physicians and surgeons have had where they have these plans now. They found it was better to get away from the insurance company's hiring someone on a salary and offering to furnish medical service on that basis, desiring to retain a physician by a deposit.

DR. T. K. GRUBER: I believe at the San Francisco meeting of the American Medical Association, action was taken upon the matter of health insurance in particular, that there was no objection to health insurance that was paid in cash indemnities as opposed to payment to the individual who rendered the service. I believe that was brought up by this discussion, and it was changed on the floor of the House, as they were reading it, to conform with the action of the House of Delegates at San Francisco.

DR. R. J. HUBBELL (Kalamazoo): May I ask a question? I wonder if we can have a clarification of the third sentence under Recommendation V: "It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness," etc.

It doesn't seem that recommendation is good to me. I would like to have it enlarged upon.

DR. LUCE: The doctor's question is in reference to the last sentence in the first paragraph of Recommendation V, relative to relieving the attending physician of the certification of illness and of recovery. In brief, it is taking the physician off the spot.

DR. HUBBELL: I understand that, Doctor, but perhaps we are relinquishing some opportunity and prerogative we might have. Many times we are on the spot, but I think it might be better to be on the spot than to be under the control of some-higher employee of the insurance company.

DR. LUCE: That was discussed at great length. I think you can all see that the doctor is right in bringing up this point, and yet the final conclusion of the committee and of the House of Delegates was that it was a safer proposition to leave it as it was written.

DR. GRUBER: Mr. Speaker, if Dr. Luce will remember, when this came on the floor of the House they had to take a recess, and about fifty men went out and conferred with the Chairman of the Committee, and we were held up about twenty minutes or longer while this was being discussed and rewritten. There was a great deal of discussion on just this subject.

One of the ideas in mind was that some person wanted to know if he had to make out a whole stack of reports on the proposition, and so the discussion went from one thing to another until finally they recessed and sent the committee out to rewrite it, and this is the way this group of men who went out with the Chairman came in and presented it.

THE SPEAKER: As to the Report of the Delegates on the San Francisco meeting of the American Medical Association, that report is in the Handbook. I am going to call on Dr. Gruber to give us a synopsis of that June meeting, so that we can match that up with our supplemental report and handle the report as a whole rather than individually.

DR. T. K. GRUBER: Mr. Speaker and Members of the House of Delegates: The members of the House of Delegates apparently had certain ideas in mind regarding the whole question of the attitude of the public toward the medical profession, and several groups had talked over the matter of all of the adverse publicity that medicine has had through the magazines, through the various publications in the United States, and certain attempts were made in various ways to try to establish that which was adopted here today, a Public Relations Committee for the American Medical Association and the medical profession in this country. Michigan introduced an amendment to the Constitution and By-Laws which would have set up a Public Relations Commission, separate and apart from the present organization. By that I don't mean it was to be a different group but it was to be a new set-up in the form of a Public Relations Committee.

There were other resolutions presented on the same subject. The recommendations as they were presented failed to pass, but Dr. Luce's committee report, which was to the effect that there was some discussion, recommended that the American Medical Association continue with the same amount of vigor and the same amount of pressure the policies that they have pursued for a great many years. They recommended, however, that probably a little oil poured on the waters might help to set up a better relation between the public and the medical profession.

The American Medical Association had invited Miss Josephine Roche to appear before the organization and present her views on her interpretation of what the Technical Committee, which was to have a meeting a month later, had in mind. Miss Roche was not able to be present. It was explained by Dr. Olin West, the Secretary, that Miss Roche is a very busy woman in her own personal affairs, that she has a great many industrial activities, and that certain of these activities were in such position that she couldn't leave them at this particular time, and she begged leave to be excused from coming to the meeting, and sent Dr. W. F. Draper of the Public Health Service to read her paper.

I believe this paper has been published and you have read it. If my memory serves me correctly, the import of the paper was that if medicine doesn't do something, somebody else is going to. That summed up the story very well.

The House of Delegates then authorized repre-

sentatives of the American Medical Association to attend this conference at Washington, which was held on the 18th of July, and most of you have seen the results of that. It has been talked over and part of what Dr. Luce read here is an outgrowth of that particular conference.

Another thing that was brought out was the matter of differentiating between indemnity insurance and insurance—I should say probably insurance-in-kind. I was informed that the House of Delegates of the American Medical Association was not opposed to indemnity insurance in which the money was paid to the individual who was insured and he, in turn, reimbursed the doctor or the hospital or whomever it might be.

The roentgenological group and, I believe, the pathological group and certain other groups, introduced a resolution to the House of Delegates, the purpose of which was to affirm what was already a matter of common knowledge; that is, that the roentgenologists and the pathologists are practitioners of medicine. I have forgotten just how many groups were included in that, but at least the roentgenologists and pathologists are included.

In regular session, the House of Delegates voted to amend the association's "Ten Commandments" concerning socialized medicine to disapprove the inclusion of special medical services, such as pathological examination, x-ray work and anesthesia, in group hospital contracts and providing for removal of hospitals from association's approval list where either the public or profession is exploited.

The idea was in mind that any hospital that transgressed from the principles of the American Medical Association would no longer be approved as a proper place for internes and residents.

I move the adoption of the report as printed in the Handbook.

The motion was seconded by Dr. C. F. Snapp.

THE SPEAKER: Is there any discussion?

The motion was carried.

THE SPEAKER: It is a peculiar thing that this year we have the largest attendance of delegates we have ever had—101 out of a possible 106.

Now, we will take up the continuation of the supplementary report which Dr. Luce has been going over. Are there any more questions you wish to ask?

DR. LUCE: Mr. Speaker, I move the adoption of the supplementary report.

The motion was seconded by Dr. Stapleton of Wayne and carried.

THE SPEAKER: Thank you, Dr. Luce.

IX. NEW BUSINESS

Is Dr. Reeder in the House? Will you please come forward?

IX (1). KEY PRESENTED TO FRANK E. REEDER, M.D.

Gentlemen, I want you to behold the delegate from Flint. He has been coming down to the House of Delegates for about twenty-six years, more or less. He was Vice Speaker of the House of Delegates for two or three years, and he was Speaker for two years. He has entertained us during the evening hours on many occasions. Sometimes we laughed at his jokes, but we had heard them before. (Laughter) But now and again he used to come along with some new ones. He has been on a number of committees for the State Medical Society and has worked very hard on them. He was a very good Speaker of this House of Delegates, and now he is back as a plain delegate again.

In recognition of all the faithful service that he has given to this Society, the House of Delegates has had made a key, which, in behalf of the Michigan State Medical Society, I wish to present to you, Dr. Reeder, and may God bless you. (Presenting key to Dr. Reeder) (Applause)

DR. FRANK E. REEDER: Mr. Speaker, if this little memento means anything of what little value I may have added to organized medicine during the past twenty-five years, then I am very happy.

It will also make me very happy, as it reminds me over those many years of the many activities, of the many social functions, of the many friendships, which I have had in this legislative body. In fact, I am very happy over the whole thing.

Mr. Speaker, I thank you. I desire to thank my preceptor, Dr. Luce, under whose tutorship I struggled along. One day he said to me, "Reeder, after all, it isn't so hard to make a race horse out of a mule."

I thank you, the House of Delegates. (Laughter and Applause)

DR. LUCE: A question of privilege. Two moments ago I made a motion in this House. I would interpret that as out of order as I am not a member of the House, and to keep the record clear I wish someone else would straighten that out. Kindly accept my apologies. I am so used to talking.

THE SPEAKER: Inasmuch as you were asked to do this by the Speaker and were accorded the privilege of the floor, therefore, you have the right to make a motion. The Chair so rules.

IX (2). MEMBERSHIP TRANSFERS FROM OTHER STATES

THE SPEAKER: Dr. Leland, there is a question that we would like to put up to you, and that is the question of a member of the Indiana Medical Society —we will take Indiana as an example—who has paid his dues for the year 1938, and then along in the middle of the year transfers to Michigan and desires to become a member of the Michigan State Medical Society and his local county unit. How do we split those dues and through whom do we get it?

DR. LELAND: I am unable to give you the exact ruling adopted in the various amendments to the Constitution and By-Laws of the American Medical Association concerning membership in adjoining county medical societies and state medical societies. However, in general it is a matter of agreement between the two medical societies concerned.

THE SPEAKER: On the question I asked Dr. Leland, we ought to clarify that situation one way or the other. Either we ought to charge that member dues for the balance of that year when he comes into Michigan, or we ought to forget it for that year if he pays the other society.

This subject was discussed by Drs. Ellet, Wenger, Callery, Gruber, Wade, Andrews, C. E. Simpson, the Secretary, O'Donnell, Perkins and Torgerson.

DR. DUTCHESS: Since it is evident that the solution of this question requires some information which is not now available, I move the question be laid on the table.

The motion was seconded by Dr. A. E. Stickley of Ottawa and carried.

X. RESOLUTIONS

DR. WILLIAM C. ELLET: I have here a resolution I would like to offer.

Dr. Ellet read the Resolution on Nurses' Training Schools.

X (1). NURSES' TRAINING SCHOOLS

Whereas, Many Nurses' Training Schools have been abolished throughout the State on the advice of Board of Regents of Nurses, and

Whereas, A Resolution was introduced in the House of Delegates at the 1937 meeting asking for guidance and assistance in formulating a plan by which Training Schools for Nurses might be reëstablished in the smaller hospitals of this State, and

Whereas, no definite report has been returned to this

House of Delegates as to such action,

Be It Hereby Resolved by the House of Delegates of the Michigan State Medical Society that a Special Committee, with adequate representation from these affected areas be appointed to study this specific problem and return with definite information at the next meeting of Nurses.

THE SPEAKER: This resolution will be referred to the Committee on Resolutions.

X (2). EMERITUS AND RETIRED MEMBERSHIPS

Dr. Dutchess read a Resolution submitting for consideration as Emeritus Members the names of Dr. George E. Clark and Dr. Robert W. Gillman.

The Delegates from Wayne County are pleased to submit for consideration as Emeritus members the names of Dr. George E. Clark of Detroit, and Dr. Robert Gillman of Detroit. These two distinguished gentlemen have been elected to Honor membership in the Wayne County Medical Society and their qualifications more than satisfy the requirements of the By-laws of the State Society for Emeritus membership. They have been recommended for this additional honor by The Council of the Wayne County Medical Society.

Dr. George E. Clark was born in Norwich, Ontario, 1861. He was graduated from the Detroit College of Medicine in 1888. He has been a member of his local and state medical societies since 1889. He is a general practitioner.

Dr. Robert W. Gillman was born in Detroit, 1865. He was graduated from the Detroit College of Medicine in 1887, and has been a member of his local and state medical societies since 1890. His specialty is ophthalmology.

C. E. DUTCHESS, M.D.
DAVID I. SUGAR, M.D.

THE SPEAKER: This resolution will be referred to the Reference Committee.

A Resolution, submitting the name of Dr. Fred Freeman for consideration as an Emeritus Member, was read by Dr. Clarence E. Toshach of Saginaw.

Whereas, Dr. Fred Freeman has, for more than fifty years, practiced medicine faithfully and honorably with great devotion to his patients.

The Saginaw County Medical Society recommends that he be made a member Emeritus of the Michigan State Medical Society.

THE SPEAKER: This resolution will be referred to the Reference Committee.

A resolution submitting the name of Dr. Joseph Addison Crowell for Emeritus Membership was read by Dr. E. M. Libby of Dickinson-Iron.

The Dickinson-Iron Counties Medical Society wish me to propose the name of Dr. Joseph Addison Crowell of Iron Mountain for Emeritus membership in the Michigan State Medical Society.

Dr. Crowell has practiced medicine in Michigan for fifty-eight years, and has been a member of his county and state medical societies continuously for more than twenty-five years.

E. M. LIBBY, M.D.

THE SPEAKER: This will be referred to the Committee also.

A resolution submitting the name of Dr. E. D. Brooks of Kalamazoo for Emeritus Membership was read by Dr. Fred M. Doyle of Kalamazoo.

Dr. E. D. Brooks of Kalamazoo, Michigan, is recommended by the Kalamazoo Academy of Medicine for Member Emeritus in the Michigan State Medical Society. His qualifications are as follows: B.S., Michigan State College, 1876; Graduate, University of Michigan Homeopathic Medical College, June 23, 1885; Vice President of Hahneman Society during Senior year; began general practice in Flushing, Michigan, 1885; Assistant to chair of Ophthalmology and Otolaryngology, and Assistant Surgeon to Eye, Ear, Nose and Throat of Homeopathic Hospital at University of Michigan, 1894-95; special course in Eye, Ear, Nose and Throat, College of Chicago, 1898; special course in Allgemeine Krankenhaus, Vienna, August to October, 1906; went to Kalamazoo in 1907 and practiced Eye, Ear, Nose and Throat there since. Now practically retired. Eighty-four years of age, September 6, 1938.

A resolution submitting the name of Dr. Harry G. Berry for Emeritus Membership was read by Dr. R. F. Salot of Macomb.

Whereas, Harry G. Berry, M.D., has been a practicing physician in Macomb County for over fifty years, and

Whereas Dr. Harry G. Berry has been a member of the Macomb County Medical Society for over twenty-five years,

Be it hereby resolved that he be made an Emeritus Member of the Michigan State Medical Society.

R. F. SALOT,
Delegate, Macomb County.

THE SPEAKER: This will also be referred to the Reference Committee on Resolutions.

Resolution submitting the name of John W. Handy for Emeritus Membership was read by Dr. Robert Scott of Genesee.

The Genesee County Medical Society wishes to present the name of John W. Handy, M.D., as Member Emeritus in the Michigan State Medical Society.

Dr. Handy was born October 5, 1852, graduated from the University of Michigan in 1884, and has been a member of the Genesee County Medical Society since 1887.

His name has been voted on favorably for this honor by the Genesee County Medical Society.

Resolution submitting for Emeritus Member the name of Dr. Archibald Blythe Thompson was read by Dr. G. H. Southwick of Kent.

The Kent County Medical Society recommends as a Member Emeritus in the Michigan State Medical Society one of its most highly respected members, Doctor Archibald Blythe Thompson.

Doctor Thompson was born at Blythe, Ontario, seventy-three years ago, and has practiced medicine in Grand Rapids for fifty-one years. He is a graduate of the Royal College of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow in the year 1887. Following graduation he came to Grand Rapids where he entered into practice on November the first of that same year. He is a charter member of the Kent County Medical Society and has been active in all its affairs since its beginning in 1902.

The Kent delegation is proud to recommend Doctor Thompson most highly as a Member Emeritus.

X (3). PHYSICIANS AND CULTISTS

Dr. C. F. DeVries of Ingham read a resolution regarding consultation with irregular practitioners.

Whereas, organized medicine receives many inquiries concerning the relations of the various cults to the regular profession, particularly pertaining to the osteopath and the optometrist, and

Whereas, members of medical societies are frequently requested to consult with or otherwise associate in a professional capacity with irregular practitioners, and

Whereas, a consultation with a cultist is usually futile and such consultation lowers the honor and dignity of the profession in the same degree to which it elevates the honor and dignity of the irregular practitioner, therefore

Be It Resolved That the House of Delegates of the Michigan State Medical Society regards any voluntary association in other than in an emergency, with irregular practitioners, as unethical.

THE SPEAKER: This will also be referred to the Reference Committee on Resolutions.

X (2). RETIRED MEMBERSHIPS

Dr. Perkins of Bay City read a resolution asking Retired Membership for Dr. John Weed.

At a regular meeting of the Bay-Arenac-Iosco-Gladwin Medical Society, held at Bay City, January 8, 1938, the following resolution was passed:

Be It Hereby Resolved—That this Society recommend to the House of Delegates at their next Annual Meeting, that Dr. John Weed of East Tawas, a member of this Society, be granted a Retired Membership in the State Society, according to Section V, Article III of the Constitution.

Dr. Weed has fulfilled the requirement for Retired Membership in the State Society, having been a member of the County and State Societies since entering the practice of Medicine following his graduation from the Michigan College of Medicine and Surgery, March, 1895.

He has always taken an active interest in the affairs of both Local and State Societies. He is now retired from active practice.

Therefore we present to you the name of Dr. John Weed of East Tawas for a Retired Membership in the Michigan State Medical Society, and

We hereby request that his name be inscribed on the Rolls of the State Society as such a Member.

A resolution was read by Dr. J. C. Webster of Huron-Sanilac County asking for Retired Membership for Dr. A. J. Howell.

The Huron-Sanilac County Medical Society wishes to present the name of Dr. A. J. Howell of Bayport, Michigan, for Retired Membership in the Michigan State Medical

Society. He has had a continued membership from 1920 to 1937, inclusive, and now retired on account of his health.

X (4). CITIZENSHIP

Dr. William C. Ellet of Berrien County read a resolution on requiring of foreign graduates full citizenship in the United States.

Whereas, The license to practice medicine and surgery in many countries is limited strictly to citizens of these countries; and

Whereas, In addition to holding full citizenship, each applicant is required, in several of these countries, to show that his medical education was pursued and completed in said countries; and

Whereas, Foreign graduates in medicine and surgery, in increasing numbers, are seeking admittance to the practice of medicine in these United States; and

Whereas, In order to convey adequately to these applicants a full and satisfactory knowledge of the American conception of patriotism and of ethical ideals in medicine; it is necessary that a period of residence be required; therefore be it

Resolved, That in addition to the requirements for foreign graduates, as outlined in a resolution adopted by the House of Delegates for the American Medical Association in 1936, it is highly desirable that an additional requirement of full citizenship in the United States of America be demanded; and be it further

Resolved, That the House of Delegates of the Michigan State Medical Society heartily approve and endorse the present rules and regulations of the State Board of Medical Registration, which has enforced the above since 1930.

THE SPEAKER: That particular resolution, I think, is redundant because I am informed the State Board requires it now.

DR. ELLET: I talked with Dr. McIntyre about this today and he would like to have the opinion of this House of Delegates and the State Medical Society backing him up.

X (5). CHANGE IN COUNCILOR DISTRICTS

Dr. F. J. O'Donnell of Alpena read a resolution referring to the councilor district distribution of counties.

The Thirteenth Councilor District is now composed of the following counties: Alpena, Alcona, Presque Isle, Antrim, Charlevoix, Cheboygan, Emmet. Alpena, Alcona, and Presque Isle Counties are practically one medically under the auspices of the Alpena County Medical Society, while the remainder of the counties—Antrim, Charlevoix, Cheboygan and Emmet—are under the auspices of the Northern Michigan Medical Society.

Believing this distribution to be geographically incorrect and also believing it would be for the best interests of all concerned, including the whole Michigan State Medical Society, be it resolved

"That the members of the Alpena County Medical Society be transferred to the Tenth Councilor District, and the members of the Northern Michigan Medical Society be transferred to the Ninth Councilor District, and that the Seventeenth Councilor District be renumbered the Thirteenth Councilor District."

We offer this for your kind consideration.

THE SPEAKER: This particular resolution is merely confirmatory of one in The Council report and will be referred to the Committee on Resolutions.

X (2). EMERITUS MEMBERSHIP

Dr. Harvey Hansen of Calhoun read a resolution asking for Emeritus Membership for Dr. George C. Hafford of Albion.

We offer a resolution from the Calhoun County Medical Society urging Emeritus Membership for Dr. George C. Hafford of Albion, graduate of the University of Michigan in 1887, and a member of our County Medical Society for fifty years.

X (6). MERGER OF DELTA-SCHOOLCRAFT

Dr. O. S. Hult of Delta County read a resolution on merging Delta County and Schoolcraft County Societies.

At the request of Delta County and Schoolcraft County Medical Societies

Resolved that the Delta County Medical Society and the Schoolcraft County Medical Society be merged as one, the combination to be called the "Delta-Schoolcraft Medical Society."

THE SPEAKER: This resolution is also confirmatory to the one which was in The Council report.

X (7). PROPOSED CONSTITUTIONAL AMENDMENT RE MEMBERSHIP

DR. PERKINS: I move that an amendment be made to Article III, Section 1 of the Constitution of the Michigan State Medical Society, on page 123 of the Handbook.

The motion is that membership in the County Medical Society on a basis not including membership in the Michigan State Medical Society is not recognized. The above amendment to be added to Article III, Section 1, following the words, "and whose local and State dues have been paid."

THE SPEAKER: The amendment is referred to the reference committee and, if approved, will be acted upon next year.

We will now recess.

(Intermission)

VIII (4). REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

THE SPEAKER: We will now hear from Dr. Insley, Chairman of the Reference Committee on Reports from Standing Committees.

DR. STANLEY W. INSLEY: The Committee wishes to beg your indulgence for the length of time taken in making out this report. I think that you are all aware, of course, of the tremendous amount of detail involved in going through some score of different committee reports, as well as the exhibits and the report itself, dealing with the distribution of medical care. It is a tremendous job, and may I here publicly thank the members of my Committee for all the help in time of need that they have given me, and to this Society.

The Reference Committee on Reports of Standing Committees reports as follows:

VIII (4a). REFERENCE COMMITTEE ON LEGISLATIVE COMMITTEE [VI (1)]

Dr. Insley read from his report.

The Reference Committee on Reports of Standing Committees begs to report as follows:

Legislative Committee—We recommend the acceptance and adoption of the Annual Report of the Legislative Committee with the exceptions of Paragraph 4 of the Report and No. 3 of the Recommendations, as printed in the "Handbook for Delegates" (Pages 49-51).

DR. INSLEY: I move the adoption of this report.

The motion was seconded by Dr. C. K. Hasley.

THE SPEAKER: Do you want to pass right over, or do you want to look that up and discuss it?

DR. INSLEY: I can elucidate. Paragraph 4 of the Report and No. 3 of the Recommendations had to do with the Welfare Reorganization Referendum which will be held this fall. Now, regardless of the merits for or against this enactment, it was felt unnecessary at the present time to include such items in this particular final report.

THE SPEAKER: Is there any further discussion?

DR. HENRY COOK: As this is worded, I think the Committee is justified in taking its position, but I would like to make this explanation.

The matter of the position of the Michigan State Medical Society in regard to the referendum was left open by The Council and the Executive Committee, and each group was asked to prepare information and arguments both for and against with the understanding that we would take no position but would publish the information as they might prepare it. That is the position.

If nothing is done and we are not allowed to publish this information, it places the Michigan State Medical Society, and I think your agencies which contact them, in a very, very embarrassing position.

We are not asking and do not feel that our profession should take a definite stand because of the difference in opinion, but certainly there can be no reason for stifling the information or keeping it from the profession. Certainly it is justifiable to

present that information as each group may formulate its arguments for the information of the profession, because frequently as we go around among these county societies the doctors ask us what they should do, and we have said that information pro and con would be presented in THE JOURNAL. That I think we should take into consideration in the action.

DR. O. D. STRYKER: I think this whole question will automatically die because I was supposed to contact Mr. Mel McPherson to give the opposing side on the welfare referendum, and he was so confident that the whole set-up would be defeated that he didn't even consider it worth his time or the time of his colleagues to prepare this article for publication in THE JOURNAL.

The time is rapidly drawing to a close. I had thought we would contact him again, but personally, as far as I am concerned, I would say, let the whole matter drop.

THE SPEAKER: All those in favor of the motion signify by saying "aye"; opposed. Carried.

VIII (4b). REFERENCE COMMITTEE ON JOINT COMMITTEE [VI (2)]

Dr. Insley read the report of the Committee on The Representatives to Joint Committee on Health Education.

The Representatives to Joint Committee on Health Education—We recommend the acceptance and adoption of the Annual Report of the Representatives to Joint Committee on Health Education, as printed in the "Handbook for Delegates" (pages 52-53). We heartily concur with their recommendations and suggest that they further extend the publication in matters of health instruction to the public in the daily press and to continue their preparation and publication of booklets on mental, personal and social hygiene to be distributed in the public schools.

DR. INSLEY: I move the adoption of this report.

The motion was seconded by Dr. Harvey Hansen, put to a vote and carried.

VIII (4c). REFERENCE COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION [VI (6)]

Dr. Insley read the Report on the Committee on Postgraduate Medical Education.

Committee on Postgraduate Medical Education—The Committee on Postgraduate Medical Education is to be commended for the large amount of work so effectually consummated during the past year, this work being extended to 15 per cent more practitioners than in previous years.

The question of securing a continuation study center in Detroit was advanced and your Committee believes that further study should be given this matter as suggested by the Committee on Postgraduate Medical Education.

Also approved by the Reference Committee are:

1. Improved methods of interne teaching.
2. Unit system of credits proposed.
3. Addition of the Chairmen of several committees dealing with related subjects (as ex-officio members of the Postgraduate Medical Education Committee).
4. Recommendation for qualifications for certification of physicians attending extramural courses.
5. That the time limit for completion of postgraduate work entitling to certification be not over six years.

The Committee on Postgraduate Medical Education is urged to continue the progress reported in establishing an Endowment Fund for postgraduate education.

We recommend the acceptance and adoption of the annual report of this committee.

DR. INSLEY: I move the adoption of this report.

The motion was seconded by Dr. Louis J. Hirschman and carried.

VIII (4d). REFERENCE COMMITTEE ON PUBLIC RELATIONS COMMITTEE [VI (4)]

Dr. Insley read the Report on the Public Relations Committee.

Public Relations Committee—We recommend the acceptance and adoption of the Annual Report of the Public Relations Committee as printed in the "Handbook for Delegates" (Pages 88-90).

DR. INSLEY: I so move the acceptance and the adoption.

The motion was seconded by Dr. C. S. Kennedy, put to a vote and carried.

VIII (4e). REFERENCE COMMITTEE ON CANCER COMMITTEE [VI (7)]

Dr. Insley read the report on the Cancer Committee.

Cancer Committee—We recommend the acceptance and adoption of the Annual Report of the Cancer Committee as printed in the "Handbook for Delegates" (Pages 70-71).

DR. INSLEY: I so move the acceptance and adoption.

The motion was seconded by Dr. William J. Stapleton, put to a vote and carried.

VIII (4f). REFERENCE COMMITTEE ON MEDICO-LEGAL COMMITTEE [VI (5)]

Dr. Insley read the report on the Medico-Legal Committee.

Medico-Legal Committee—We recommend the acceptance and adoption of the Annual Report of the Medico-Legal Committee as printed in the "Handbook for Delegates" (Pages 92-95).

DR. INSLEY: I so move the acceptance and adoption.

The motion was seconded by Dr. C. K. Hasley, put to a vote and carried.

VIII (4g). REFERENCE COMMITTEE ON PREVENTIVE MEDICINE COMMITTEE [VI (8)]

Dr. Insley read the report on the Preventive Medicine Committee.

Preventive Medicine Committee (Its Advisory Committee on Tuberculosis Control and Its Advisory Committee on Syphilis Control)—Your Reference Committee recommends the acceptance of the printed reports of this Committee and its Advisory Committees ("Handbook for Delegates" Pages 72-79), with the suggestion that postgraduate instruction for physicians interested in the various phases of preventive medicine, as outlined in the reports, be continued. It is further recommended that the other studies mentioned should be continued.

DR. INSLEY: I so move the acceptance and adoption of this report.

The motion was seconded by Dr. A. L. Callery, put to a vote and carried.

VIII (4h). REFERENCE COMMITTEE ON ETHICS COMMITTEE [VI (9)]

Dr. Insley read the report on the Ethics Committee.

Ethics Committee—We recommend the acceptance and adoption of the Annual Report of the Ethics Committee as printed in the "Handbook for Delegates" (Page 91).

DR. INSLEY: I so move the acceptance and adoption.

The motion was seconded by Dr. Charles Ten Houten, put to a vote and carried.

VIII (4i). REFERENCE COMMITTEE ON DISTRIBUTION OF MEDICAL CARE [VI (3)]

DR. INSLEY: Now we come to the Report of the Committee on the Distribution of Medical Care. There was a considerable amount of material in the Handbook as well as in the exhibits passed out yesterday. Your Committee felt that the condensation of this material would be very much in order, and so, under certain headings, we have attempted to cover the entire range of that report.

For purposes of convenience, you may start off with so-called Insurance.

Your Committee reports as follows:

Dr. Insley read that portion of the report under the heading "Insurance."

Insurance—We approve the principle of Voluntary Hospital Insurance, providing that Hospital Insurance be so defined that it does not include professional services by a Doctor of Medicine.

We also recognize the merits of certain principles in Voluntary Health Insurance, and

We therefore urge that Recommendation IV of the "General Program of Medical Care" as defined by the American Medical Association September 17, be adopted in principle by the Michigan State Medical Society.

We further recommend that the Committee on Distribution of Medical Care continue with more detailed studies of an acceptable insurance program—these studies to be presented to a special meeting of the House of Delegates in the near future.

RECOMMENDATION IV—GENERAL PROGRAM OF MEDICAL CARE

"We approve the principle of hospital service insurance which is being widely adopted throughout the country. It is capable of great expansion along sound lines and we particularly recommend it as a community project. Experience in the operation of hospital service insurance or group hospitalization plans has demonstrated that these plans should be confined themselves to provision of hospital facilities and should not include any type of medical care. We recognize that health needs and means to supply needs vary throughout the United States. Studies indicate that the health needs are not identical in different localities, but that they usually depend on local conditions and therefore are primarily local problems. We therefore encourage county or district medical societies with the approval of the State Medical Society, of which each is a component part to develop appropriate means to meet their local requirements. In addition to insurance for hospitalization, we believe it is practicable to develop cash indemnity insurance plans to cover in whole or in part the costs of emergency or prolonged illness. Agencies set up to provide such insurance should comply with state statutes and regulations to insure their soundness and financial responsibility.* We are not willing to foster any system of compulsory health insurance. We are convinced that it is a complicated bureaucratic system which has no place in a democratic state. It will undoubtedly set up a far reaching tax system with great increase in the cost of government; that it would lend itself to political control and manipulation there is no doubt.

We recognize the soundness of the principles of workmen's compensation laws and recommend the expansion of such legislation to provide for meeting the cost of illness sustained as a result of employment in industry. We repeat our conviction that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. Further development of group hospitalization and establishment of insurance plans on the indemnity principle to cover the cost of illness will assist in solution of these problems.

DR. INSLEY: I move that these recommendations be adopted.

The motion was seconded by Dr. A. T. Hafford.

THE SPEAKER: Is there any discussion on this motion?

DR. LOUIS J. HIRSCHMAN: I merely wish to call the attention of the House of Delegates to the fact that we did not include Recommendation 5 of the A.M.A. report, not because we were either opposed or in favor of it. In fact the majority of the Committee felt it should not be included at this time merely because we did not want to introduce any more controversial material to cloud the issue as to health and hospital insurance at this time.

I merely wanted to make that remark to show you we did not overlook it.

THE SPEAKER: Are there any further comments on the motion?

The motion was put to a vote and carried.

DR. INSLEY: We next took up the phase of medical aid to the medically indigent.

Dr. Insley read the Report of the Committee under the heading "Medical Aid to Medical Indigents."

Medical Aid to Medical Indigents—A person is medically indigent when he is unable, in the area in which he resides, through his own resources to provide himself and his dependents with proper medical, dental, nursing, hospital care, pharmaceutical supplies and therapeutical appliances without depriving himself or his dependents of necessary food, clothing, shelter and similar necessities of life. The government is responsible for this group.

Any program of medical relief to the indigents should allow for the American system of free choice of physician and the personal patient-physician relationship.

We recommend:

1. That a State Commission of Medical Relief be established whose function shall be purely administrative—this Department to deal only with the medically needy and indigents.

The Director of this Department shall be a graduate in Medicine and legally licensed to practice medicine in Michigan.

2. We also recommend that the study of details on such an indigent plan be referred jointly to the Legislative Committee and to the Committee on Distribution of Medical Care.

DR. INSLEY: I move the acceptance and adoption of this report.

The motion was seconded by Dr. Otto O. Beck, put to a vote and carried.

DR. INSLEY: Next we had to deal with the Medical Finance Service.

Dr. Insley read that part of the report under the heading "Medical Finance Service."

Medical Finance Service—We recommend the acceptance and adoption of the report on Medical Finance Service as printed in Exhibit F, and urge that such service be extended throughout the State wherever feasible.

The communications from Dr. Grant James and from Dr. Hubbell were referred to the Committee on Distribution of Medical Care for further study.

Now then—the Committee on Distribution of Medical Care, and especially its Chairman, Dr. Ralph Pino, have done a monumental work in investigation. We feel that a hearty vote of thanks and appreciation should be rendered these gentlemen.

DR. INSLEY: I move the acceptance and adoption of this report.

The motion was seconded by Dr. R. M. McKean, put to a vote and carried.

DR. INSLEY: The last has to do with laboratories.

Dr. Insley read the report on "Laboratories."

Laboratories—We recommend the acceptance and adoption of the recommendations set forth in the report on "Laboratories" as printed in Exhibit G.

DR. INSLEY: I move the acceptance and adoption of this report.

The motion was seconded by Dr. Warren B. Cooksey, put to a vote and carried.

DR. INSLEY: The communications from Dr. Grant James and from Dr. Hubbell were referred to the Committee on Distribution of Medical Care for further study.

Now then, the Committee on Distribution of Medical Care, and especially its Chairman, Dr. Ralph Pino, have done a monumental work in investigation. We feel that a hearty vote of thanks and appreciation should be rendered these gentlemen.

I move that this be done.

The motion was seconded by several, including Dr. Hirschman, and carried by rising vote. (Applause.)

DR. HIRSCHMAN: I move the adoption of the report as a whole.

The motion was seconded by Dr. G. H. Southwick, put to a vote and carried.

*and have the approval of the county and state medical society under which they operate.

THE SPEAKER: Now, Dr. Pino, I think you ought to get up and take a bow.

Dr. Pino arose. (Applause)

And in accordance with that, I think Dr. Insley ought to take a bow, too. (Applause)

THE SPEAKER: Now we will take up new business.

DR. S. L. LOUPEE: I have two brief resolutions. It seems to me that one should have come under Unfinished Business, as a similar one was presented before.

X (2). EMERITUS MEMBERSHIP

Dr. Loupee read a resolution recommending the name of John H. Jones for Emeritus Membership.

Cass County Medical Society presents the name of Dr. John H. Jones for Emeritus membership in the State Society.

Dr. Jones graduated from the Medical Department of the University of Michigan more than fifty years ago and has been continuously a member of the County and State Societies for forty-five years or more.

X (8) W. C. McCUTCHEON, M.D., DECEASED

Dr. Loupee read a resolution expressing appreciation of the services of Dr. W. C. McCutcheon.

Whereas, Dr. W. C. McCutcheon, late of Cassopolis, Cass County, was throughout his professional life a devout, loyal and faithful member of organized medicine in Michigan.

Whereas, Dr. McCutcheon fell victim to a deadly attack of coronary thrombosis while in attendance at the yearly meeting of the House of Delegates at Grand Rapids in 1937, therefore

Be it resolved, that special mention be made of the services of Dr. McCutcheon and that the Secretary enter this resolution upon the minutes of this meeting.

And be it further resolved, that a copy of this be sent to his family, as an expression of the esteem in which Dr. McCutcheon was held by the House of Delegates and the doctors of the Michigan State Medical Society.

THE SPEAKER: These will be referred to the Committee on Resolutions.

Is there anything else under the head of New Business to come at this session?

DR. LOUIS J. HIRSCHMAN: I move we recess until eight o'clock.

The motion was seconded and carried and the meeting recessed at five forty-five o'clock.

Monday Evening Session

September 19, 1938

The meeting was called to order at eight-thirty o'clock, Speaker Riley presiding.

THE SPEAKER: The Third Session of this meeting will now come to order.

We will have a report from the Credentials Committee.

The report of the Credentials Committee is that we have seventy-seven delegates here.

There is a motion made and seconded that seventy-seven delegates constitute the roll call of the House. All those in favor signify by saying "aye"; opposed. It is carried.

VIII (5). REFERENCE COMMITTEE ON RESOLUTIONS (X)

THE SPEAKER: Dr. Reeder, Chairman of the Reference Committee on Resolutions, will report.

VIII (5a) REFERENCE COMMITTEE ON EMERITUS AND RETIRED MEMBERSHIPS [X (2)]

DR. FRANK E. REEDER: Mr. Speaker and Members of the House: Your Reference Committee on Resolutions reviewed the resolutions as presented, and we now desire to offer them for your disposal.

The following names were offered by resolution for Membership Emeritus:

Dr. George E. Clark of Wayne
Dr. Fred Freeman of Saginaw
Dr. Joseph Crowell of Dickinson-Iron
Dr. E. D. Brooks of Kalamazoo
Dr. Harry G. Berry of Macomb
Dr. John W. Handy of Genesee
Dr. Archibald Thompson of Kent
Dr. George Hafford of Calhoun
Dr. John H. Jones of Cass
Dr. Robt. W. Gillman of Wayne

All of these gentlemen having fulfilled the qualifications necessary for Membership Emeritus, Mr. Speaker, I move the adoption of the resolutions for these gentlemen to Membership Emeritus in the Michigan State Medical Society.

The motion was seconded by Dr. Robb and carried.

DR. REEDER: Mr. Speaker, the following two men were recommended by resolution for Retired Membership:

Dr. John Weed of Bay-Arenac-Iosco-Gladwin.
Dr. A. J. Howell of Huron-Sanilac

Having fulfilled the qualifications, Mr. Speaker, I move the adoption of the resolutions for their membership.

The motion was seconded by Dr. Donald R. Brasie and carried.

VIII (5b). REFERENCE COMMITTEE ON DR. McCUTCHEON [X (8)]

DR. REEDER: Mr. Speaker, the resolution pertaining to Dr. W. C. McCutcheon, late of Cassopolis, Cass County, was as follows:

Dr. Reeder read the resolution. (See page ..)

I move the adoption of this resolution.

The motion was seconded by Dr. O'Donnell and carried.

VIII (5c). REFERENCE COMMITTEE ON PHYSICIANS AND CULTISTS [X (3)]

DR. REEDER: Mr. Speaker, a resolution was offered pertaining to the relation of physicians and cultists, as was outlined in the *Journal of the A.M.A.*, April 30, 1938. The resolution is as follows:

Dr. Reeder read the resolution.

Physicians and Cultists—Many inquiries concerning the relations of the various cults to the regular profession have been received. The inquiries pertain particularly to the osteopath and the optometrist. Some of our members are giving lectures in osteopathic and optometric schools and addresses before their societies. Some members are associated by a common waiting room in offices with them. Some members are by mutual agreement professional associates principally in the field of surgery. There are some instances of partnership in practice. All of these voluntarily associated activities are unethical. Such relations certainly do not "uphold the dignity and honor of (our) profession" or "exalt its standards." In case of emergency no doctor should refuse a sufferer knowledge or skill which he possesses to the sufferer's harm but this is quite a different matter from that of a consultant or practitioner who by consulting or practicing with him assists a cultist to establish himself as compeent and on the same basis of medical knowledge as a doctor of medicine. By the very nature of the education and training of each, a consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree to which it elevates the honor and dignity of the irregular in training and practice. Practicing as a partner or otherwise has the same effect and objection. Teaching in cultist schools and addressing cultist societies is even more reprehensible, for such activities give public approval by the medical profession to a system of healing known to the profession to be substandard, incorrect and harmful to the people because of its deficiencies. There hardly can be a voluntary relationship between a doctor of medicine and a cultist which is ethical in character.

Mr. Speaker, I move the adoption of the resolution.

The motion was seconded by Dr. Wenger, put to a vote and carried.

VIII (5d). REFERENCE COMMITTEE ON CITIZENSHIP [X (4)]

DR. REEDER: Mr. Speaker, a resolution pertaining to the requiring of foreign graduates having full citizenship in the United States:

Dr. Reeder read the resolution. (See page 1027.)

Mr. Speaker, I move the adoption of the resolution.

The motion was seconded by Dr. H. W. Wiley.

THE SPEAKER: Is there any discussion?

DR. BRASIE: I have one query. Is there anything in this resolution that prevents exchange fellowships between our universities and the universities of England, for instance, such as has occurred in the past between the University of Michigan and the St. Bartholomew School in England?

DR. ELLET: I might say that when this question came up, that was the first thing that entered my mind. I talked with Dr. McIntyre about it, and these men are not considered as practicing medicine. They have been and will continue to be granted every right that we would have.

DR. E. D. SPALDING: May I suggest that this be temporarily tabled and we come back to it?

THE SPEAKER: Your suggestion will be followed.

VIII (5e). REFERENCE COMMITTEE ON NURSES' TRAINING SCHOOLS [X (1)]

DR. REEDER: A resolution pertaining to Nurses' Training Schools:

Dr. Reeder read the resolution. (See page 1025.)

Mr. Speaker, I move the adoption of the resolution.

The motion was seconded by Dr. R. E. Spinks and carried.

DR. REEDER: Mr. Speaker, with the exception of the resolution which was temporarily tabled, that completes our report, and with that exception, I move, sir, the adoption of the Report of the Committee as a whole.

The motion was seconded by Dr. Ralph Pino and carried.

THE SPEAKER: Now, with that exception, you will be excused for a few minutes, Dr. Reeder, until we get Dr. McIntyre up here and then we will take up the other resolution again.

VIII (6). REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

We will take up Dr. Torgerson's report.

VIII (6a). REFERENCE COMMITTEE ON CHANGE IN COUNCILOR DISTRICTS, AND MERGER OF DELTA-SCHOOLCRAFT [X (5 and 6)]

DR. WILLIAM R. TORGERSON: Mr. Speaker and Delegates: There were two resolutions proposed this afternoon that should have been proposed as By-Laws. They can be considered together because they have the effect of reallocating certain counties in regard to their councilor districts.

The first one has to do with putting together in one organization Delta and Schoolcraft County Medical Societies to be known as the Delta-Schoolcraft County Medical Society.

The second one has to do with a reallocation of the counties now in the Thirteenth Councilor District. The members of the Alpena County Medical Society in that district will be transferred to the Tenth Councilor District, and the members of the Northern Michigan Medical Society will be transferred to the Ninth Councilor District. This would mean the present Thirteenth Councilor District would be no longer in existence, so the Seventeenth Councilor District is renamed the Thirteenth and the Seventeenth is cancelled.

That means the By-Laws would be changed as follows: In Chapter 5, under "The Council," Section 12, the First District, Second District, Third District, Fourth District, Fifth District, Sixth District, Seventh District, and Eighth District will be left as they are:

District Nine will read as it is at present, with the addition of the Northern Michigan Medical Society, which includes Antrim, Charlevoix, Cheboygan and Emmet.

District Ten will read as at present, with the addition of Alpena, Alcona and Presque Isle Counties.

District Eleven will be as it is.

District Twelve will read Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger.

District Thirteen will include the counties at present in District Seventeen, and District Seventeen will be abolished.

I move that these two amendments be passed at this time as they have been read.

The motion was seconded by Dr. C. S. Kennedy and carried.

THE SPEAKER: Now, to make this legal this has to go over from one session to another, so we will have a recess, if someone will make a motion for a recess, of one minute and reconvene and take it up again, and it will be legal.

Will someone make a motion to recess?

DR. R. L. FINCH: I move we recess.

The motion was seconded by Dr. Umphrey and carried.

THE SPEAKER: We are now recessed for about one minute.

(Recess)

THE SPEAKER: We are now called back into session. The second evening session is now open.

I would like a report from the Credentials Committee.

THE SECRETARY: I hold in my hand the credentials of seventy-eight registered delegates, and move that they constitute the roll call of this session.

The motion was seconded by Dr. William J. Stapleton.

The motion was carried.

THE SPEAKER: Dr. Torgerson, will you make your report?

DR. GRUBER: Mr. Chairman, I move that the matter of amending the By-Laws be taken from the table.

THE SPEAKER: There is a motion before the House that the resolution be taken from the table. Is there a support to it?

The motion was seconded by Dr. Clinton, put to a voted and carried.

DR. TORGERSON: I move that the By-Laws be amended as outlined before this was laid on the table.

The motion was seconded by Dr. A. E. Catherwood, put to a vote and carried.

VIII (6b). REFERENCE COMMITTEE ON PROPOSED CONSTITUTIONAL AMENDMENT ([X (7)]

DR. TORGERSON: Mr. Speaker, there was also an amendment to the Constitution introduced today, in which Article III is to be amended as follows:

Article III, Section 1, now reads:

"This Society shall consist of active members, honorary members, associate members, retired members, and members emeritus. Members shall be members of Component County Societies who have been certified to the Secretary of this Society and whose local and State dues have been paid."

The amendment was to add at the end of that sentence, the sentence:

"Membership in the County Medical Society on a basis not including membership in the Michigan State Medical Society is not recognized."

It was the opinion of the Reference Committee that the Constitution as it is at present provides that one cannot be a member of the local county unit without being a member of the State Society, when it sets forth in Article III, Section 2, "Qualifications": "Active members shall comprise all the active members of a component county society." For this reason, we thought this amendment was superfluous, and did not recommend its being considered. However, a vote on it will have to be taken at the next meeting, I believe next year.

I move it be laid over until next year to be voted on at that time.

The motion was seconded by Dr. Stapleton and carried.

THE SPEAKER: Is there any further Unfinished Business?

XI. ELECTIONS AND PLACE OF ANNUAL MEETING

We will now conduct the elections of the Society.

I will appoint four tellers: Dr. Novy, Dr. Finch, Dr. Wenger and Dr. Kennedy.

XI (1). COUNCILOR OF ELEVENTH DISTRICT

The first election to be held is that of Councilor of the Eleventh District to succeed Roy H. Holmes, M.D., of Muskegon. Nominations are now in order.

DR. E. O. FOSS (Muskegon): Mr. Speaker, I want to nominate a man who has been attending for the last three years, a man who has been very dynamic in his work. I nominate Dr. Roy Holmes.

THE SPEAKER: Dr. Roy Holmes has been nominated. Is there a second?

The nomination was seconded by Dr. E. N. D'Alcorn of Muskegon.

THE SPEAKER: Are there any other nominations?

Remember, nominations for councilor must be made by the delegates from that councilor district.

If there are no other nominations will someone kindly move that the nominations be closed?

DR. FOSS: I move the nominations be closed and the unanimous vote of this assembly be cast for Dr. Holmes for Councilor.

The motion was seconded by Dr. Snapp, put to a vote and carried unanimously.

THE SPEAKER: Mr. Secretary, will you cast the unanimous ballot for Dr. Holmes.

THE SECRETARY: I have so cast.

XI (2). COUNCILOR OF TWELFTH DISTRICT

THE SPEAKER: The next election is that of Councilor of the Twelfth District to succeed F. C. Bandy, M.D., of Sault Ste. Marie.

DR. E. S. SCOTT (Chippewa-Mackinac): I would like to nominate Dr. F. C. Bandy to succeed himself.

THE SPEAKER: Dr. Bandy has been nominated. Do I hear a second?

The nomination was seconded by Dr. R. E. Spinks of Luce County.

DR. JAMES H. FYVIE (Schoolcraft): I nominate C. D. Hart, M.D., of Luce County.

The nomination was seconded by Dr. Brasie.

DR. HARVEY HANSON: I move the nominations be closed.

The motion was seconded and carried unanimously.

THE SPEAKER: The tellers will pass the ballots and you may vote on these nominees.

The ballots were cast and counted.

THE SPEAKER: I now declare Dr. Hart elected Councilor.

XI (3). COUNCILOR OF NEW THIRTEENTH DISTRICT

Nominations are in order for a councilor to succeed Dr. W. A. Manthei of Lake Linden.

DR. G. M. WALDIE (Houghton): I place in nomination Dr. W. A. Manthei, who has served this District as Councilor since its organization some seven years ago.

THE SPEAKER: Are there any other nominations?

DR. MANTHEI: I would like to have my name withdrawn from the list of candidates, if there is a list, because I think I have served my time, and besides that, that district is the wrong number now. I am not a candidate for re-election. (Laughter)

THE SPEAKER: Are there any other nominations?

DR. S. C. MASON (Menominee): I would like to present Dr. W. H. Huron of Iron Mountain.

The nomination was seconded by Dr. Vivian Vandeventer.

DR. E. M. LIBBY: I move the nominations be closed, and the Secretary cast the unanimous ballot.

The motion was seconded by Dr. Wenger and carried unanimously.

The ballot was cast by the Secretary.

THE SPEAKER: As the result of an automobile accident, Dr. Bandy is in the hospital at Grayling and so is Dr. Rhind, the delegate from Chippewa. I think a motion from this body to send a message of condolence to these men and their families, and possibly a few flowers, would be in order now.

DR. ROBB: I so move.

The motion was seconded by several and carried.

THE SPEAKER:

XI (4). DELEGATES TO A.M.A.

We will now pass on to the election of delegates to the American Medical Association. We will elect these delegates one by one tonight.

The first one is to succeed Dr. Henry Luce.

DR. DUTCHESS: How long the man whom I wish to nominate has been serving organized medicine, I don't know. I do know that in 1925 I saw him conduct the Council of the Wayne County Society week after week, and I never ceased to admire his ability as presiding officer, his industry, and his devotion to the County Society.

He went to the State meeting as a delegate. The years rolled by. In 1931, in the House of Delegates of the A.M.A. at Philadelphia, happening to be present as a guest, I saw him represent Michigan in a spirited contest, brilliantly and successfully. He was then serving not only Wayne County and Michigan State but American Medicine.

Again the years roll by. Just the other day I saw in the paper that he was leading the fight of the Michigan delegates to introduce new business in the House of Delegates at A.M.A. in Chicago.

As you all know, this is a critical time, and at such a time I feel it a great privilege as Chairman of the Wayne Delegation to nominate Dr. Henry Luce as Delegate to the A.M.A.

The nomination was seconded by Dr. Spalding.

THE SPEAKER: Dr. Luce has been nominated and supported. Are there any other nominations to succeed Dr. Henry Luce?

DR. INSLEY (Wayne): I move the nominations be closed, and the Secretary cast the ballot to elect Dr. Luce.

The motion was seconded by R. A. Springer and carried unanimously.

The ballot was cast by the Secretary.

THE SPEAKER: The next delegate to be elected is the delegate to succeed Dr. Thomas K. Gruber.

DR. LOUIS J. HIRSCHMAN: I believe these are critical times, and it is very, very poor policy at a time like this to change horses in midstream. The value of a delegate to his State Society is gathered by his repeated return and his reported contacts with the delegates of other states.

It gives me great pleasure to place in nomination a man to succeed Dr. Gruber, a man we all know and admire, Dr. Thomas J. Gruber of Wayne.

DR. SPALDING: I would like to second this nomination and call to your attention the fact that at a recent meeting of the A.M.A. in San Francisco, Dr. Gruber introduced a resolution on the floor to establish a Public Relations Committee to assist Dr. Fishbein in handling that problem for the A.M.A.

DR. PERKINS: I move the nominations be closed and the Secretary cast the unanimous ballot for the re-election of Dr. Gruber.

The motion was seconded and carried and the ballot was cast by the Secretary.

THE SPEAKER: Dr. Gruber has been re-elected.

This, gentlemen, is Dr. Hart, your new Councilor. (Applause)

DR. HART: Thank you, gentlemen. It is a privilege, and I realize the honor you have bestowed on me. I assure you I shall do my best to work for the doctors of the Twelfth District and the Upper Peninsula and for organized medicine. (Applause)

THE SPEAKER: The next delegate to be elected is one to succeed Dr. Jacob D. Brook. Nominations are now open.

DR. WENGER: Gentlemen, it gives me great pleasure to bring to you one who has been long in your service. He was the President of his County Society for over twenty years, in fact, their representative in this body. From here he went to the A.M.A. and was there over twenty years as a representative. He is a Past President of this organization. It gives me great pleasure to present Dr. J. D. Brook to succeed himself.

The nomination was seconded.

THE SPEAKER: Are there any other nominations?

DR. ROBB: There is a man who has served this Society through a great many years and under very exasperating and exacting circumstances. He has been a member of this organization for twenty-eight years. He served as Speaker of this House for two years. He has never failed, in my knowledge, to serve with unusual ability.

I feel bad that Dr. Sheets of Eaton Rapids is not here to handle this, because he knows really how to put it on and he could describe this man perfectly.

Dr. Frank Reeder has served this organization unusually well. Unfortunately, a short time ago he did not feel well. Tony is now in excellent shape, and I know that he will serve you well. I place in nomination a man who is a prince of good fellows and has promised that he will carry on, as he always has, to the fullest extent for organized medicine—the name of Dr. Frank Reeder.

THE SPEAKER: Dr. Reeder has been nominated. Is there a second?

DR. BRASIE: It gives me very great personal pleasure to second the nomination of Dr. Frank E. Reeder, a man respected by this State Society, and not only respected but loved for all his fine sterling qualities by his own Society of Genesee. I second the nomination.

DR. BROOK: May I have the privilege of the floor?

THE SPEAKER: Yes.

DR. BROOKS: Members of this House of Delegates: Just a word of explanation. I am sorry there was a misunderstanding this morning, or this afternoon, in regard to the report of the Delegates to the A.M.A. I prepared a supplementary report to the one which was printed in the Handbook, and I also prepared a report of the Chicago session. In the forenoon there was not opportunity given to present this report, and then it was found that Dr. Luce was to give a stenographic report of the Chicago convention in the afternoon, which, of course, would be much superior to what anyone would write about that special Chicago session.

For thirty-six years that I have been a member of the State Medical Society, you have seen fit to honor me in various capacities. You have elected me President and Speaker of the House, and for twenty-three years you have elected me Delegate to the American Medical Association. I have attended all of those meetings and two special sessions. For all of these honors, I am extremely grateful and thankful to the Society.

But all things have an end, and I think I have served my apprenticeship, and therefore, I desire that my name be withdrawn. I am not a candidate for Delegate to the American Medical Association. I would, if I had the power, like to make the motion to make unanimous the election of Dr. Reeder, but I am not a delegate to this House and cannot do it. Thank you again. (Applause)

THE SPEAKER: With the permission of the one who made the nomination and the seconder, that is withdrawn. Is that all right?

It was agreed.

Are there any other nominations?

DR. R. M. MCKEAN: I move the nominations be closed and Dr. Reeder elected unanimously, and that Dr. Brooks' very fine action in retiring from this slate be commended.

The motion was seconded by Dr. Wenger, put to a vote and carried unanimously.

THE SPEAKER: Gentlemen, our Ex-President, Dr. Henry E. Perry. (Applause)

Will you come forward, Dr. Perry, and let them all take a look at you and see how good-looking you are?

Dr. Perry was escorted to the platform.

THE SERGEANT-AT-ARMS: Mr. Speaker, I would like to present to you Dr. Henry E. Perry, Past President of the Michigan State Medical Association. (Applause)

DR. HENRY PERRY: Mr. Speaker and Gentlemen: I always thought Dr. Phil Riley was a friend of mine, but I was sitting down in the President's room having a rest and Phil sent the Sergeant-at-Arms down to bring me up here. You know, last Saturday I was getting ready to come down here and left home this morning at seven o'clock and met a couple of my friends, and they said, "Are you going down to Detroit Monday?" I said, "Yes." They said, "Why, I thought you were all through with that medical stuff." I said, "No, I will never get it out of my system, as long as the same old gang is down there, the best bunch of fellows in the State of Michigan. Whenever I have a chance to see them, I am going to see them." I am very glad to be with you tonight, gentlemen, and I thank you. (Applause)

THE SPEAKER: Dr. Perry, you are not half as glad to be here with us as we are to have you here. We certainly miss you at the conventions when you are unable to come and we are always glad to have you with us.

DR. REEDER: Just a few minutes ago you listened to a very splendid talk. In view of that and in view of the many, many years of his service, I think it would be only fitting and proper that the House of Delegates vote a suitable emblem to Dr. Brooks. I so move.

The motion was seconded by Dr. R. L. Novy and carried.

THE SPEAKER: We will continue with the elections.

The next delegate to be elected is the Delegate to succeed Dr. Claude R. Keyport of Grayling. Nominations are now in order.

DR. A. E. CATHERWOOD: I would like to place the name of Dr. Keyport in nomination to succeed himself as delegate to the A.M.A.

The nomination was supported by Dr. O'Donnell.

THE SPEAKER: Are there any further nominations?

DR. C. S. KENNEDY: I move the nominations be closed and the Secretary instructed to cast the unanimous ballot for the election of Dr. Keyport.

The motion was seconded by Dr. Louis J. Hirschman, put to a vote and carried, and the Secretary cast the ballot.

XI (5). ALTERNATE DELEGATES TO A.M.A.

THE SPEAKER: We will now move on to the nominations of alternate delegates.

The first is one to succeed Dr. T. E. DeGurse.

DR. WILLIAM R. CLINTON: I would like to nominate a man who has been around here many years and has always done what he is supposed to do. I would like to see him have a chance to be Sergeant-at-Arms at A.M.A. That is Dr. J. J. O'Meara.

The nomination was seconded by Dr. Hirschman.

DR. ROBB: I move the nominations be closed and the Secretary be instructed to cast the ballot.

The motion was seconded by Dr. A. L. Callery, put to a vote and carried.

The next alternate to be elected is to succeed Dr. C. S. Gorsline of Battle Creek. Nominations are now in order.

DR. HARVEY HANSEN: I would like to nominate Dr. Gorsline to succeed himself.

The nomination was seconded by Dr. Robb.

THE SPEAKER: Are there any other nominations?

DR. C. K. HASLEY: I move the nominations be closed and the Secretary instructed to cast the unanimous ballot.

The motion was seconded by Dr. Torgerson and carried.

The Secretary cast the ballot.

THE SPEAKER: The next is the Alternate to succeed Dr. R. H. Denham.

DR. SNAPP: I should like to place in nomination the name of Dr. R. H. Denham to succeed himself.

The nomination was seconded by Dr. Wenger of Kent.

THE SPEAKER: Are there any other nominations?

DR. TORGERSON: I move the nominations be closed.

The motion was seconded by Dr. Southwick and carried.

XI (6). PLACE OF ANNUAL MEETING

THE SPEAKER: Grand Rapids boys stuck to it pretty well on that last election, and they also sent in an invitation for us to go to Grand Rapids for our next meeting. We got the invitation in two or three forms from organizations up there. I think that is the only invitation we have. Will someone make a motion that we travel to Grand Rapids next year?

DR. HIRSCHMAN: I move we hold our convention in Grand Rapids next year.

The motion was seconded by Dr. Wenger and carried unanimously.

THE SPEAKER: It is Grand Rapids next year.

XI (7). PRESIDENT-ELECT

Now we come to the election of a President-Elect. Nominations are now in order.

DR. GROVER C. PENBERTHY: Mr. Speaker, Dr. Perry, Officers and Members of the House of Delegates: It is a pleasure for me, as a member of the Wayne County Delegation, to present to you the name of a gentleman who has been active in organized medicine for some thirty-odd years. I think the record will show that he took part in the establishment of the first postgraduate clinic to be founded in this state. He has followed through in all this program of medicine. He has served as a member of The Council for many years, and acted as Secretary of the State Society.

During this session we have listened to the problems that we as doctors face, and it requires the action and advice and the guidance of someone who has had experience. We are all delighted to think that next year we are to have as our President, Dr. Luce.

It gives me great pleasure to present the name of Dr. Burton R. Corbus of Grand Rapids as President-Elect. (Applause)

THE SPEAKER: Dr. Corbus has been nominated.

DR. TORGERSON: It gives me great pleasure, as a member of Kent County Medical Society, to second the nomination of Dr. Corbus.

THE SPEAKER: Are there any other nominations?

DR. ELLET: I move the nominations be closed and the unanimous ballot be cast for Dr. Corbus.

The motion was seconded by Dr. Robb, put to a vote and carried unanimously.

THE SPEAKER: Dr. Corbus will please come forward. (Applause)

THE SERGEANT-AT-ARMS: Mr. Speaker, I would like to present to you Dr. Corbus.

DR. BURTON R. CORBUS: Mr. Speaker and Members of the House of Delegates: As Chairman of the Council and as Acting Secretary, I have in the past had the privilege of standing on this platform and talking to you, but I never have been quite so perturbed and so emotionally upset as I am now. To be acclaimed President-Elect rather than elected is indeed a very great honor, and I feel that it indicates a friendliness which I cherish and which is itself indicative that you have that confidence in me which I hope I can justify. It gives me courage to help you to meet the problems which are going to be serious. There are going to be large problems in these next two years, and it gives me confidence, because since you know me well you must know my weaknesses, and if you think I have the ability to help you and to help this Society during the next two years, I must have it.

There are those who demand that we junk the old model with which we have practiced medicine in these last one hundred years and take on a new streamline chariot which the advocates claim will carry the multitude more safely and more comfortably. But there are a great many parts in the old model which are not yet outworn, and there is a lot of it that must be saved. There is a greatness in the old model with which we have practiced medicine that we can't afford to lose, and in any event, to give a bit of a lighter note to this, we will certainly not be at all influenced by the suggestion which is found in the old Chinese proverb. It goes somewhat like this: She is a wise virgin who, when rape is inevitable, accepts the situation with enjoyment. (Laughter and Applause)

THE SPEAKER: We have a By-Law which has caused us a lot of trouble every year when we try to abide by it. In the years gone by we always got into a jam. This year we elected these alternates individually to avoid that jam, and now I guess we are in a jam with the By-Laws anyway.

The By-Laws read: "Alternate delegates at large so elected shall have relative seniority according to the respective numbers of votes received by them, and such seniority rank shall be designated at the time of election."

We have to designate the seniority rank of the alternate delegates. I think if someone will make a motion to put three numbers in the hat—1, 2, 3—and we draw them out in the order in which we elected them tonight and see which one will be 1, 2, or 3, that would solve it. Will someone make a motion to that effect?

DR. CLINTON: I move we do that.

The motion was seconded by Dr. Hansen of Calhoun.

DR. SPALDING: Mr. Speaker, I appreciate your motives, and I trust the audience will appreciate mine, but the By-Laws are a little more specific than that.

THE SPEAKER: Will someone offer a solution to the problem?

DR. SPALDING: Follow the By-Laws.

THE SPEAKER: Everyone was elected unanimously, so the vote is the same, and we have to decide at the time of the meeting.

DR. SPALDING: The solution could be made by passing ballots and having each man write the three names and a number after each name in the order he wishes them to rank.

DR. WENGER: I move the rules be suspended and

we solve the problem by drawing numbers from the hat.

DR. SPALDING: I rise to a point of order. Unfortunately, although you can suspend the rules of action of the meeting, you cannot suspend the By-Laws.

THE SPEAKER: It doesn't say in the By-Laws how they shall be designated, so your motion is in order.

The motion was seconded and carried.

THE SPEAKER: Dr. Holmes, will you come up and hold the hat? Dr. Finch will draw them out.

The names were drawn from the hat.

THE SPEAKER: The first name out is Alternate No. 1.

The names were drawn in the following order: (1) Dr. Denham; (2) Dr. O'Meara; (3) Dr. Gorsline.

THE SPEAKER: Mr. Vice Speaker, will you please take the chair.

Dr. Martin H. Hoffmann, Vice Speaker, took the chair.

XI (8). SPEAKER

THE VICE SPEAKER: The next order of business is the election of a Speaker of the House of Delegates. The chair will now receive nominations.

DR. LOUIS J. HIRSCHMAN: May I have the distinguished privilege and honor of nominating for the office of Speaker for the coming year Dr. Phil A. Riley of Jackson.

The nomination was seconded by Dr. Kennedy.

THE VICE SPEAKER: The name of Dr. Phil Riley has been placed in nomination for Speaker. (Applause)

DR. SPALDING: I move the nominations be closed and the Secretary instructed to cast the unanimous ballot for the election of Dr. Riley.

The motion was seconded by Dr. H. F. Dibble and carried unanimously.

Dr. Riley resumed the chair.

THE SPEAKER: Gentlemen, I am overwhelmed with surprise.

XI (9). VICE SPEAKER

We will have nominations for Vice Speaker of the House of Delegates.

DR. REEDER: I desire to nominate Dr. Martin H. Hoffmann for Vice Speaker.

The nomination was seconded by Dr. O'Donnell.

DR. BRASIE: I move that the nominations be closed and the unanimous ballot be cast for Dr. Hoffmann.

Motion was seconded and carried unanimously.

THE SPEAKER: Dr. Hoffmann is elected Vice Speaker.

Is there anything to come under the head of Unfinished Business?

Is there anything to come under the head of New Business or Unfinished Business?

DR. GROVER C. PENBERTHY: We have listened to the report of the delegates to Chicago at the A.M.A. I would like to move, Mr. Speaker, that a vote of thanks be given to the officers of the State Society who have participated in this activity, as well as the delegates to the A.M.A., and to Dr. Pino and Dr. Insley, who have done a good job in trying to clarify in the minds of all of us a responsibility that rests with the medical profession.

I move that a vote of thanks be given to that group who helped to iron out the problems for the Michigan State Medical Society and the other Society.

I understand from Dr. Luce that the Michigan delegation played a big part in the proceedings at Chicago. I think that reflects the work of Dr. W. H. Marshall, who instituted the movement to carry on a survey and the action that has been carried through with the other Society officers for the past five years.

The motion was seconded by Dr. Catherwood and carried.

VIII (5d). REFERENCE COMMITTEE ON CITIZENSHIP [X (4)]

THE SPEAKER: Will Dr. McIntyre and Dr. Reeder come forward?

Dr. Reeder, will you continue with your report?

DR. REEDER: Mr. Speaker. Dr. McIntyre, when I present the resolution, as submitted to the Reference Committee on Resolutions, pertaining to the requiring of foreign graduates full citizenship in the United States, a question was raised by one of the delegates in reference to how this applied to the exchange of fellowships with the universities of foreign countries. No one was able to answer, so we had to send out a messenger for you. I, therefore, at this time, would like to have you answer to the House that question.

DR. J. E. MCINTYRE: The matter of the exchange of professors of the foreign schools was arranged two years ago in June. That is declared to be the non-practice of medicine. There is no objection to the exchange of professorships with any of the foreign schools that are recognized and accepted by the University of Michigan and the College of Medicine of Wayne University, because they are not considered as practicing medicine. The work is simply didactic and for lecture purposes.

This became effective by the Michigan State Board of Medicine in 1930. The first citizenship papers were required and one year of work as a full-time attendant, passing work in a Class A school of medicine in the United States, and one year of approved interneship in a hospital approved for interneship.

In October, 1935, the requirement was raised to complete citizenship, and two years ago, at a meeting of the State Board of Medicine in Ann Arbor, the matter came up and was presented by a committee of the faculty at the University of Michigan, and that was a satisfactory arrangement for the exchange of professorships.

Does that answer your question, Mr. Speaker?

THE SPEAKER: I believe it does.

DR. REEDER: Mr. Speaker, I move the adoption of the resolution.

The motion was seconded by Dr. Brasie, put to a vote and carried.

DR. REEDER: Mr. Speaker, I move the adoption of the report of the Committee as a whole.

The motion was seconded by Dr. Clinton, put to a vote and carried unanimously.

THE SPEAKER: We have a guest in the House, in the person of the Health Commissioner of the State. I would like to have him come forward and take a bow. Dr. D. W. Gudakunst! (Applause)

Dr. Gudakunst came forward and bowed.

THE SPEAKER: Is there anything to come up under Unfinished Business?

DR. BRASIE: I move that the House of Delegates extend its thanks and appreciation to Wayne County Medical Society for the entertainment they have provided and are about to provide.

The motion was seconded by Dr. Torgerson, put to a vote and carried.

XII. ADJOURNMENT

THE SPEAKER: I want to take the privilege of expressing my personal appreciation of the interest of the delegates and their attendance and of the work of those who served on Reference Committees. They did noble work.

Upon motion, regularly made and seconded, the meeting adjourned at ten o'clock. Subject to the call of the Speaker in pursuance with the adoption of report of Reference Committee on Standing Committees (Committee on Distribution of Medical Care).

MICHIGAN'S DEPARTMENT
OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner
LANSING, MICHIGAN

EXPANSION OF HEALTH SERVICES

"One of the real problems confronting the practicing physician in providing adequate medical care is Michigan's need for extensive diagnostic laboratory services," declared Dr. Don W. Gudakunst, State Health Commissioner, in his address recently on "New Developments in Planning for Public Health and Medical Care" before the annual Conference of Social Work at Lansing.

Modern medicine cannot depend on the unaided five or six senses of the physician, he continued. The day has passed when the entire armamentarium of the doctor could be carried in his little black bag. This black bag today has come to be more of a badge, a symbol, rather than a thing of real service. The diagnostic laboratories call for structures of brick and mortar backed by huge sums of money for the purchase of equipment and employment of a technical staff. It is here the science of medicine is to be found, impersonal, accurate and expensive. It is science serving art. This is one place the state can step in and help unsnarl the tangle of social and financial difficulties.

In Michigan it is hoped that within the year we can add throughout the state additional laboratory services for those unable to pay for or procure such adjuncts to the art of medicine. In areas where laboratories do not exist we hope to build with the assistance of federal funds new buildings and to equip and staff them so that there can be better medical care at no increased cost to the people through the medium of the practicing physician. Where there are already existing laboratories large enough to meet the needs we have a different problem. In such places it is a universally admitted fact that such scientific diagnostic aids are not available to any save the comparatively economically secure. Governmental subsidies granted to such laboratories will enable them to expand, to render care to more nearly the entire population.

But this is only an example of the planned expansion and development of public health. It must be of concern to the health officer that people die of preventable or postponeable causes, other than the communicable diseases. He must be concerned with these causes of death and with the factors contributing to their operation. It is most readily seen that of all the factors so contributing to lack of medical care there are two of great importance—poverty and ignorance. These are not the only factors, but we feel they are not only the most important but also the two most readily amenable to proper treatment.

We do not feel it wise to attempt to solve this entire problem by any one step or at any one time. We do not know how. We must feel our way cautiously so as to avoid waste and the creation of uncontrollable destructive forces, which once unleased might wreck not only all we hoped to build but all that previously had served.

We are, therefore, recommending that those persons who are securing their subsistence from the government in direct relief, old age assistance, or WPA be given first consideration. We are suggesting that there be added to the amount allocated for food, shelter, clothing, and education of these people a small additional sum to be used to purchase medical care. This would not be great—not over

fifty cents a month at the most. This sum could be spent by the state to pay for medical care secured by the patient from his own doctor, dentist or nurse. Such funds in order to be adequate would have to be collected from a large enough group to insure a sufficient reserve to meet emergencies and inequalities in distribution.

These are but a few highlights illustrating our present thinking for expansion of public health and medical care. These have been cited not because they are brilliantly outstanding but because they illustrate certain basic principles. In the first place the establishment of or the subsidizing of diagnostic centers is entirely an additional service. It does not in any way interfere with programs that are already successfully serving the people. It merely extends the field in two ways: to those who cannot purchase services of this nature at this time and to those for whom such services are not available even though they can purchase them.

The supplying of medical care through the practicing physician at the state expense for those groups who are without resources for any of their needs definitely limits the problem. By working with this group administrative technic will be learned. Then in due course of time the program can be enlarged to include that vast army of borderline cases who are able to meet the demands of food, shelter and clothing but cannot meet the catastrophic events of sickness. We are no more capable of revising the medical practice scheme than we are of making over the economic structures. We must take our problem piecemeal.

Such programs as these cannot be worked out or put into operation by government, by social agencies or by medical men working alone. The successful application of such ideas calls for careful thought and complete coöperation on the part of all agencies concerned. It is the function of the Department of Health to bring such agencies together so that forces may be mobilized to wage war against disease. No one should develop a mistaken idea that it is the function of any department of health or any branch of government to administer these services. It is our function to serve as intermediary agents between those who on the one hand command the forces of preventive and healing arts and those on the other hand who are in need of such services but are unable to secure them.

MORTALITY DECREASING

Mortality reports for the first seven months of 1938 compiled by the Bureau of Records and Statistics show a decline in total deaths from 32,634 in 1937 to 29,636 this year. Infant mortality, too, is down from 2,673 in 1937 to 2,437 in 1938. Maternal deaths slightly exceed last year's figures when an all-time low rate for this cause was set. There were 188 maternal deaths last year compared to 200 this year. Births have increased from 52,649 in 1937 to this year's total of 55,341 for the seven-months' period.

Comparative mortality figures for the major communicable diseases in 1937 and 1938 are indicated in the table below:

Communicable Disease Mortality, 1937-1938

Disease	July, 1938	July, 1937	7 Months, 1938	7 Months, 1937
Pneumonia	126	149	1,814	2,852
Tuberculosis	179	198	1,163	1,324
Typhoid Fever	1		14	10
Diphtheria	4	6	23	32
Whooping Cough	17	12	63	77
Scarlet Fever	5	2	67	112
Measles	6	3	95	7
Smallpox				1
Meningitis	1	4	13	30
Poliomyelitis	1	1	3	1
Syphilis	20	41	221	233
Gonorrhea		1	5	3

PRELIMINARY REPORT OF A.P.H.A. SURVEY

A meeting of the Governor's Health Coördinating Committee has been set for October 14 in Lansing to hear the preliminary report on the survey of Michigan's health services conducted by the American Public Health Association. Dr. Carl Buck, field director, and his administrative associate, Dr. G. F. Amyot, will discuss the preliminary findings they have made during the survey which started here last June.

Members of the coördinating committee and the organizations represented include Dr. M. R. Kinde, W. K. Kellogg Foundation; Dr. B. W. Carey, Children's Fund of Michigan; Dr. P. C. Lowrie, State Dental Society; Dr. L. O. Geib, State Medical Society; Dr. John Sundwall, University of Michigan; and Dr. Don W. Gudakunst, State Health Commissioner. More than a score of representatives from various official and unofficial health agencies have also been invited to hear the preliminary report.

18TH ANNUAL PUBLIC HEALTH CONFERENCE

The 18th Annual Public Health Conference, sponsored by the Michigan Department of Health and the Michigan Public Health Association, is being held this year at Grand Rapids with headquarters at the Pantlind Hotel. Sessions will begin November 9 and continue for three days in the Grand Rapids Civic Auditorium.

Physicians, health officers, nurses, sanitarians, laboratorians and health educators have been invited to attend the interesting and pertinent sessions which are being arranged by the program committee. The conference last year had an official registration of more than 1,200 persons.

The program will include discussions on the following topics: The Rôle of Sanitation in Disease Prevention, The Shiga Dysentery Outbreak, Rabies, Syphilis Control, Mental Hygiene, Pneumonia Control, Trends and Changes in Public Health Administration, Michigan's Cancer Control Program, The Nurse in the Program of Maternal and Child Heath, and The Rôle of Government in the Provision of Medical Care.

PERSONNEL

Dr. Richard Sears, epidemiologist with the Michigan Department of Health and recently acting director of the Muskegon County Health Department, has accepted a position as director of Health District No. 5, including Lake, Newaygo and Oceana counties. Dr. Sears succeeds Dr. Guy R. Post who has resigned. Headquarters of the district health department are at White Cloud.

Dr. William E. Bunney, director of the Biologic Products Division of the Michigan Department of Health for seven years, has resigned to accept a position as director of biologic products manufacturing for E. R. Squibb and Sons, New Brunswick, N. J.

Dr. George F. Forster, who has been engaged in research on pneumonia for the Michigan Department of Health during the past two years has resigned to become assistant director of the laboratories of the Illinois State Health Department at Springfield.

IN MEMORIAM

Clinton C. Wright, M.D.

Dr. Clinton Carl Wright of Detroit, died on September 14, 1938. He was born in 1876, one of a family of physicians, in Edinboro, Pennsylvania. In 1900, he received his M.D. from the Cleveland Homeopathic Medical College, and in 1902 he located in Detroit where he was in general practice to the time of his death. Dr. Wright had been a member of the Grace Hospital Staff since 1902 after serving an interneship at that hospital. He was also a member of the Wayne County Medical Society, Michigan State and American Medical Associations, the Detroit Athletic Club and the Lochmoor Golf and Country Club. Dr. Wright is survived by his wife, Mrs. Nina C. Wright; a daughter, Mrs. Frank Ford; a son, Charles H., and one grandchild.

William Alexander Hackett, M.D.

Dr. J. H. Dempster, Editor
Journal, Michigan State Medical Society
Dear Doctor:

The notice of the passing of Dr. William Alexander Hackett, my life-long friend, was received not merely with regret but with the sense of a very deep personal bereavement. My wish is simply to relieve my own heart by expressing imperfectly what is shared by many others. If a man's worth may be measured by what is said of him after death, surely Detroit had no more worthy citizen than Doctor Hackett. But good and true things were said of him while he lived. He was one among us who made no ostentatious showing of his citizenship. In his modest nature no love of display found a place, and he never sought after popularity which was alien to his nature. He was content to go through life much living unto others. He was true to his profession, true to the highest principles of that profession. To him the noble Hippocratic Oath was no mere grouping of words and phrases. He practised it as a doctor, obeyed it as a man. Doctor Hackett was a physician whose every patient was a friend. That is a legacy that few men are privileged to leave. Thrice blessed is he whose passing brings no unkind thoughts—so blessed was Dr. William Alexander Hackett.

Fraternally yours,
JAMES W. SCOTT, M.D.

Detroit, October 1, 1938.

General News and Announcements

Your 1939 Annual M.S.M.S. Convention will be held in Grand Rapids, September 19, 20, 21, and 22—*A Four-Day Scientific Meeting.* Plans are now developing rapidly for another outstanding state convention.

* * *

The Ninetieth Annual Session of the American Medical Association will be held at St. Louis, Missouri, May 15 to 19, 1939.

* * *

Don't forget your friends (see page 1052) who advertise. They make possible the publication of THE JOURNAL. Please remember your friends when you need their services.

* * *

"Mental Hygiene" was the subject of a talk given by Martin H. Hoffmann, M.D., of Eloise at the O.M.C.O.R.O. Medical Society meeting of October 21, at West Branch.

* * *

"A Medical Man's View of Socialized Medicine" was the topic discussed by President Henry A. Luce, M.D., before the District Federation of Women's Clubs in St. Johns on October 19.

* * *

Joseph K. Heckert, M.D., Lansing, addressed the Barry County Medical Society on "Treatment of Sinusitis with Special Reference to Children" at the October 13 meeting held in Hastings.

* * *

The American Medical Golfing Association will hold its Twenty-Fifth Annual Tournament at the North Hills County Club, St. Louis, on Monday, May 15, 1939.

* * *

Alvin E. Price, M.D., of Detroit gave an illustrated lecture on "Recent Advance in Serum Treatment of Pneumonia" at the meeting of the Hillsdale County Medical Society held October 27, in Hillsdale.

* * *

L. G. Christian, M.D., Lansing, addressed the Shiawassee County Medical Society in Owosso on October 20, on the subject "The Medical Gall Bladder." "The Surgical Gall Bladder" was discussed by Ralph Wadley, M.D., of Lansing.

* * *

"Serum Treatment of Pneumonia" and "Treatment of the Surgical Complications of Pneumonia" were the respective subjects of Joseph F. Whinery, M.D., and Wm. R. Torgerson, M.D., of Grand Rapids, at the meeting of the Ionia-Montcalm County Medical Society held October 11, in Greenville.

* * *

Parker Heath, M.D., and Roy D. McClure, M.D., of Detroit, were guest speakers on the program of the 1938 Convention of the Indiana State Medical Association held in Indianapolis. Doctor Heath's subject was "Management of Glaucoma." Doctor McClure spoke on "Diagnosis and Management of Cholecystitis."

* * *

The Washtenaw County Medical Society invites all the internes in the county to its meetings and extends them the privileges of the society without any dues. In a recent letter addressed to the internes, the Society writes, "It is not too early for you to be aligning yourself with organized medicine as a future alert member of one of its societies."

Printed copies of the report of the Committee on Maternal Health of the Michigan State Medical Society entitled "Maternal Care in Michigan" are available free by sending a postal card to the Executive Office, 2020 Olds Tower, Lansing. This forty-four page report contains a wealth of information on maternal care in Michigan.

* * *

The North Central Branch of the American Urological Association held its annual meeting in Peoria, Illinois, Sept. 29, to Oct. 2, 1938. Dr. John K. Ormond of Detroit presented a paper on "Necrosis of Part of Kidney with Temporary Urinary Fistula Following Section of Aberrant Vessel" and Dr. George C. Burr of Detroit presented a paper on "Utero-Vesical Fistula."

* * *

The following officers were elected for the year 1938 and 1939 by the Section on Dermatology and Syphilology at the meeting of the Michigan State Medical Society, held in Detroit, Michigan during September, 1938. Chairman—Ruth Herrick, M.D., 26 Sheldon Avenue, S. E., Grand Rapids, Michigan; Secretary—Eugene A. Hand, M.D., 801 Second National Bank Building, Saginaw, Michigan.

* * *

At the annual meeting and president's dinner of the Detroit Academy of Medicine on October 11, 1938, Dr. Edward D. Spalding was elected president, Dr. Douglas Donald, vice president, and Dr. Charles W. Lemmon, secretary-treasurer. Dr. Henry Carstens, the retiring president, became a member of the council of the Academy. As host for the evening, Dr. Carstens gave an address on Early Medical Days in Detroit.

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Dr. A. S. Wheelock of Goodrich, Michigan, an honorary member and past president of the Genesee County Medical Society, was honored by the people of Goodrich, who arranged a "Wheelock Day" is a testimonial of admiration and deep appreciation of Dr. Wheelock's service to their community. The date of the event was July 4. Dr. Wheelock was born December 7, 1861, at Bridgewater, Michigan. He attended grammar school and high school at Bridgewater and then entered the University of Michigan Medical School, where he was graduated in June, 1888.

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The Association of Military Surgeons wishes to complete its set of THE JOURNAL of the Michigan State Medical Society and is in need of the February 1937 issue. If any member can supply this number and is willing to contribute it to the Association of Military Surgeons, please write direct to H. L. Gilchrist, Major General, U. S. Army, Ret., National Secretary-Army Medical Museum, Washington, D. C., or write the Executive Office, 2020 Olds Tower, Lansing, as six other requests for this particular issue have been received.

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The Committee of Seven practicing physicians representing the American Medical Association (composed of Irvin Abell, M.D., Louisville, Ky., President of the A.M.A., Chairman; Henry A. Luce, M.D., Detroit; Frederic E. Sondern, M.D., New York; Walter E. Vest, M.D., Huntington, W. Va.; Walter F Donaldson, M.D., Pittsburgh; Fred W. Rankin, M.D., Lexington, Ky.; and Edwin H. Cary, Dallas, Tex.) met with Miss Josephine Roche and the U. S. Interdepartmental Committee and its

Technical Committee on October 31 in Washington, D. C., to confer on methods of coördinating the health activities of the nation.

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The Tuscola County Medical Society, in cooperation with the Michigan Tuberculosis Association and the city of Vassar, is conducting a survey to determine exactly how much hidden tuberculosis exists in an average American community. All 4,000 inhabitants of Vassar will be given a tuberculin test, and those who react will be given an x-ray examination. The cost will be partially covered by voluntary contributions. If every community in the country were to conduct a similar survey, tuberculosis would soon become exceedingly rare.

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Crippled and Afflicted Child Commitments, for September, 1938:

Crippled Child: Total cases, 326, of which 109 went to University Hospital; 217 to miscellaneous hospitals. From Wayne County, of the above, 11 went to University Hospital, 51 to miscellaneous hospitals, total of 62.

Afflicted Child: Total cases, 1,973, of which 254 went to University Hospital; 1,719 went to miscellaneous hospitals. From Wayne County, of the above, 32 went to University Hospital and 358 went to miscellaneous hospitals; total of 390.

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The firm of E. R. Squibb and Sons of New York dedicated the new $750,000 Institute for Medical Research, by which name it is known. It is located in New Brunswick, New Jersey. Dr. George A. Harrop is the director of the Institute. Addresses were delivered by Professor August Krogh, director of the department of animal physiology at the University of Copenhagen, and Dr. George R. Minot, professor of medicine at Harvard University. The meeting was also addressed by Dr. Abraham Flexner, of Princeton University; Dr. Russell Morse Wilder, professor of medicine in the Mayo Clinic; Mr. Carleton H. Palmer, president of E. R. Squibb and Sons; and Dr. John F. Anderson, vice president and director of the biological laboratories of E. R. Squibb and Sons.

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Talks given by the Michigan State Medical Society officers and the Executive Secretary include the following:

Speaker	*City*	*Date*	*Organization*	*Subject*
Henry Cook P. R. Urmston L. F. Foster F. T. Andrews Mr. Wm. J. Burns	St. Joseph	August 31	Berrien County Medical Society	"State Society Night"
Wm. E. Barstow Mr. Wm. J. Burns	Midland	September 1	Midland County Medical Society	"Michigan Health Conference"
Mr. Wm. J. Burns	Howell	September 2	Livingston County Medical Society	"Plans for 1939"
Wm. E. Barstow L. F. Foster	Caro	September 8	Tuscola County Medical Society	"Michigan Health Conference"
Harold A. Miller Mr. Wm. J. Burns	Battle Creek	September 27	Battle Creek Academy of Medicine	"Evils of Federalized Medicine"
L. F. Foster	Caro	October 3	Rotary Club	"Socialized Medicine as it Affects Taxpayer"
L. F. Foster	Bay City	October 4	Rotary Club	"Crippled Children"
Mr. Wm. J. Burns	Portland	October 5	Lions Club	"Evils of Federalized Medicine"
Mr. Wm. J. Burns	Owosso	October 6	Rotary Club	"Evils of Federalized Medicine"
H. H. Cummings P. R. Urmston D. W. Gudakunst L. F. Foster	Howell	October 7	Livingston County Medical Society & County Supervisors	"County Health Units."
L. F. Foster	Battle Creek	October 13	Kiwanis Club	"The Exceptional Child"
Mr. Wm. J. Burns	Belding	October 25	Lions and Rotary Clubs	"What the Medical Society Means to the Community."

Doctor, remember your particular friends, the exhibitors at your Annual Convention, when you have need for equipment, appliances, medicinal supplies and service. Here are ten of the firms which helped make the 1938 Convention a great success:

Akron Truss Company, Detroit, Michigan
A. S. Aloe Company, St. Louis, Missouri
Arlington Chemical Company, Yonkers, New York
The Bard-Parker Company, Inc., Danbury, Connecticut
Bilhuber-Knoll Corporation, Jersey City, New Jersey
Burroughs-Wellcome & Company, New York, New York
S. H. Camp & Company, Jackson, Michigan
Coca-Cola Company, Atlanta, Georgia
Cottrell-Clarke, Inc., Detroit, Michigan
R. B. Davis Company, Hoboken, New Jersey

* * *

Mr. Lawrence C. Salter, formerly science editor of the *Detroit Free Press,* and now public relations assistant to Dr. Morris Fishbein, was tendered a farewell party on October 12, in Detroit, by a number of his friends. Among those present at the affair held in the Wayne County Medical Society headquarters, were Drs. Henry R. Carstens, Wm. A. Lange, S. E. Gould, Edward G. Duffy, J. Duane Miller, Matthew Balcerski, L. J. Bailey, James Lightbody, A. S. Brunk, C. E. Umphrey, Wm. A. Hyland, L. Fernald Foster, P. R. Urmston, L. J. Hirschman, Henry A. Luce, W. B. Cooksey, C. K. Valade, T. K. Gruber, David Sugar; also Messrs. Andy Burkhart and Edgar A. Guest, Jr., of the *Free Press,* A. M. Smith of the *Detroit News,* Wm. J. Burns, J. A. Bechtel, and Harry R. Lipson. A travelling case was presented to Mr. Salter by his medical friends.

* * *

The Third Congress of the Pan-Pacific Surgical Association will be held in Honolulu, September 15 to 28, 1939. All surgeons of the Michigan State Medical Society are invited to attend for the purpose of meeting fellow practitioners from Australia, New Zealand, China, Japan, Java, Canada and the United States, and to promote a better understanding and interchange of ideas among surgeons of these countries. There will be sections in fractures and orthopedics, general surgery, gynecology, neurosurgery, ophthalmology, otolaryngology, roentgenology, plastic surgery, thoracic surgery and neurology. Further information may be obtained by writing to George W. Swift, M.D., 902 Boren Avenue, Seattle, past president of the Association; Frederick L. Reichert, M.D., Stanford University Hospital, San Francisco; or Forrest J. Pinkerton, M.D., secretary-treasurer of the Association, Young Building, Honolulu, Hawaii.

Wm. M. Donald, M.D., of 938 David Whitney Building, Detroit, is compiling a short history of the Northern Tri-State Medical Association, now in its seventieth year of activity.

The founders and early officers of this hustling and aggressive organization seem to have been careless in preserving the official documents incident to the creation and development of the society, and, hence, the historian's task is a heavy one.

Any information relative to the Society during the period between 1870 and 1885 will be highly appreciated by Dr. Donald.

* * *

A joint meeting of the Michigan Tuberculosis Association, Michigan Trudeau Society, and the Michigan Sanatorium Association was held on October 15th. The following are papers presented at this meeting, which was held in Muskegon: Some Cardiac Conditions, by Dr. William M. La Fevre of Muskegon; A Study of Basilar Lesions in Pulmonary Tuberculosis, by Dr. Lauren F. Busby, Maybury Sanatorium, Northville; Studies on the Sputum of Tuberculosis Patients Treated by Extra-Pleural Thoracoplasty, Dr. William M. Tuttle, Detroit, Dr. C. J. Stringer, Ingham County Sanatorium, Lansing, and Dr. E. J. O'Brien, Detroit; The Fate of the Contralateral Lung in Pulmonary Tuberculosis, by Dr. A. D. Calomeni of the Saginaw County Sanatorium; The Sedimentation Rate in Tuberculosis, by Drs. Donald S. Smith of Pontiac and John B. Barnwell of the University Hospital, Ann Arbor; The Anemia of Pulmonary Tuberculosis, by Dr. Maurice Braverman, Maybury Sanatorium, Northville; Hawaii, by Dr. Bruce H. Douglas; The General Practitioner in Tuberculosis by Dr. Robinson Bosworth, President, Illinois Tuberculosis Association; and a Report on Plans for the Upper Peninsula, by Dr. A. W. Newitt, of the State Department of Health.

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THIRTEENTH ANNUAL CLINIC OF THE HIGHLAND PARK PHYSICIANS' CLUB

Highland Park General Hospital, Highland Park, Detroit, Michigan
November 30, 1938

Morning Session—9:00-12:30

Clinical Pathological Conference

Donald C. Beaver, M.D., F.A.S.C.P., Pathologist, Women's Hospital, Detroit

"Placental Blood Bank"

James R. Goodall, M.D., F.C.O.G., Professor of Clinical Gynecology and Obstetrics, McGill University, Montreal, Canada.

"Clinical and Radiological Aspects of Diseases of the Paranasal Sinuses"

E. H. Shannon, M.D., F.B.A.R., Director, Department of Radiology, St. Michael's Hospital, Toronto, Canada.

J. A. Sullivan, M.B., Demonstrator in Otolaryngology, University of Toronto, Toronto, Canada.

"The Treatment of Anemia"

Russell L. Haden, M.D., F.A.C.P., Chief of Division of Medicine, Cleveland Clinic, Cleveland, Ohio.

Luncheon—12:30-2:00

Address of Welcome

Blaine T. Colman, Mayor of Highland Park.
Complimentary Luncheon by the Highland Park General Hospital.

Afternoon Session—2:00-5:00

"Carcinoma of the Stomach"

Frederick Christopher, M.D., F.A.C.S., Professor of Surgery, Northwestern University, Chicago, Illinois.

"Clinical Aspects of Water Turnover"

Martin Fischer, M.D., F.A.P.S., Joseph Eichberg,

Professor of Physiology, University of Cincinnati, Cincinnati, Ohio.

"The Philosophy of Endocrinology"

James R. Goodall, M.D., F.C.O.G., Professor of Clinical Gynecology and Obstetrics, McGill University, Montreal

Banquet—7:00 P. M.

Annual Banquet, Detroit Athletic Club (Stag)
Toastmaster: Henry A. Luce, M.D., President, Michigan State Medical Society
Speaker: Malcolm W. Bingay, Editorial Director, *Detroit Free Press,* Honorary Member, Wayne County Medical Society.

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Graduate Conferences for physicians sponsored by the Wayne County Medical Society, the Detroit Department of Health and Wayne University College of Medicine. Four conferences will be held during the month of November, all at Herman Kiefer Hospital and starting promptly at 10:00 a. m.

Wednesday, November 2—"Gestation Deficiencies" by Fred Adair, M.D., Chicago
Wednesday, November 9—"Psychiatric Aspects of Medical Practice" by Wm. S. Sadler, M.D., Chicago
Wednesday, November 16—"What the Physician in General Practice Should Know About Tuberculosis" by Henry D. Chadwick, M.D., Waltham, Mass.
Wednesday, November 23—"Fevers of Unknown Origin in Children" by Rustin McIntosh, M.D., New York City

Every member of the Michigan State Medical Society is cordially invited to attend.

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Dr. Henry A. Luce, president of the Michigan State Medical Society, is chairman of a Committee to Survey Health Needs of the State. The committee consists of Dr. Luce, chairman, Drs. E. J. O'Brien, Henry F. Vaughan, Commissioner of Health of Detroit, Dr. Cyrus Sturgis, Professor of Medicine, University of Michigan, and Dr. Paul de Kruif, noted for his ability as an author and popularizer of medicine for the layman, Mr. Wm. J. Scripts of Detroit, and Mr. Louis J. Nims of Lansing.

It will be remembered that a committee was authorized by the recent special meeting of the House of Delegates of the A.M.A. to confer with federal officials on the National Health Program. Dr. Luce has been appointed by Dr. H. H. Shoulders, speaker of the House of Delegates of the A.M.A., on the Committee, other members of which are Dr. Irving Abell, president of the A.M.A. who is chairman, and Drs. Walter F. Donaldson of Pittsburgh, Walter E. Vest of Huntington, W. Virginia, Fred. W. Rankin of Lexington, Ky., Frederick D. Sondern of New York, E. H. Cary, past president of the A.M.A., of Dallas, Texas, Rock Sleyster of Wauwatosa, Wisconsin, and Dr. Olin West, secretary of the A.M.A.

CONVENTION ECHOES

The registration at the 1938 Annual Meeting of the Michigan State Medical Society in Detroit was as follows:

Physician-members	1,594
Guests (mostly M.D.'s from other states)	302
	1,896
Exhibitors	181
GRAND TOTAL	2,077

The out-of-state guest speakers on the General Assembly program at the Detroit meeting were tremendously impressed by the generous size of the audiences which were on hand from 9:30 a.m. until 5:00 p.m. daily to hear the postgraduate

instruction brought to them at the M.S.M.S. convention. A number of essayists requested an invitation to return to Michigan for some future annual meeting.

Dr. Wm. S. Sadler of Chicago was guest speaker at the Secretaries' Conference, through the courtesy of the Kellogg Foundation. Present at the Secretaries' Conference were Dr. Stuart Pritchard, General Director of the Kellogg Foundation, Battle Creek, and Dr. M. R. Kinde, its Director of Medical Service.

Seventy-four physicians attended the Secretaries' Conference of September 20 in Detroit on the occasion of the M.S.M.S. Convention. Among the county medical society secretaries present were: Drs. M. B. Beckett, T. H. Cobb, A. L. Ziliak, F. S. Leeder, Wilfrid Haughey, T. Y. Ho, G. W. Benson, W. H. Huron, T. Wilensky, C. W. Colwell, C. E. Lemen, R. L. Waggoner, E. G. McGavran, E. W. Blanchard, R. J. Himmelberger, J. J. McCann, H. W. Porter, L. W. Gerstner, J. M. Whalen, E. T. Morden, D. C. Stephens, C. D. Hart, R. F. Salot, Florence Ames, O. O. Beck, C. G. Clippert, D. C. Bloemendaal, J. H. Burley, J. W. Rice, R. R. Howlett, Wm. M. Brace, B. I. Johnstone, B. A. Holm.

Presidents of county medical societies present were Drs. G. F. Fisher, Mark Osterlin, J. N. Scher.

Officers, councilors and committeemen of the State Society present were Drs. H. A. Luce, B. R. Corbus, J. H. Dempster, L. Fernald Foster, P. R. Urmston, P. A. Riley, M. H. Hoffmann, A. S. Brunk, I. W. Greene, V. M. Moore, J. E. McIntyre, F. T. Andrews, W. E. Barstow, H. H. Cummings, R. H. Holmes, Henry Cook, L. G. Christian, T. K. Gruber, R. B. Harkness, H. A. Miller, A. V. Wenger, G. M. Byington, J. A. Hookey, G. C. Stucky, Leon Bogart, G. D. Bos, P. E. Sutton, L. D. MacRae, L. R. Keagle, M. A. Hoffs, H. C. Hill, Wm. R. Torgerson, Hugh Robbins, D. K. Barstow, A. Bernhard.

Among the other guests were Health Commissioner Don W. Gudakunst, Drs. Stuart Pritchard, M. R. Kinde, Mr. L. C. Salter, Mr. W. L. Williams, Miss Mabel Skinner, Miss M. O. Smith, Miss Rosabelle Snohr, Miss V. M. Leahy, Mr. H. R. Lipson, Mr. Frank Lark.

President Henry A. Luce outlined the 1938-39 program of the Michigan State Medical Society to the committee chairmen at the Annual Organizational Luncheon held in Detroit on September 20. Among those present were Doctors Luce, Henry Cook, Martin H. Hoffmann, James D. Bruce, F. T. Andrews, T. K. Gruber, L. G. Christian, A. M. Campbell, W. E. Barstow, P. R. Urmston, Grover C. Penberthy, H. H. Cummings, L. O. Geib, L. Fernald Foster, Wm. A. Hyland, Henry R. Carstens, H. W. Porter, Clarence D. Hart, Charles E. Dutchess, W. H. Huron, Ralph H. Pino, Paul A. Klebba, L. C. Harvie, and Harold A. Miller.

Three hundred eleven (311) inches of copy were published in the newspapers of Detroit relative to the 1938 convention of the Michigan State Medical Society. In addition over 600 inches of copy were published in the newspapers outside of Detroit.

Dr. J. Duane Miller of Grand Rapids headed a very efficient Press Relations Committee, composed of Drs. Fred G. Buesser and David I. Sugar, of Detroit, and Dr. Miller, to which credit is due for the splendid press notices on the convention activities.

Among the newspaper representatives who covered the meeting were Lawrence C. Salter, *Detroit*

Free Press; A. M. Smith, *Detroit News,* and Miss Dorothy Williams of the *Detroit Times.*

Dr. Martin H. Hoffmann of Eloise added to his laurels for versatility by demonstrating his abilities as a song leader at the M.S.M.S. Convention. The quality of his basso profundo was thoroughly enjoyed at the Exhibitors Gridiron of September 21.

President Henry A. Luce was toastmaster on this occasion; Dr. Frank A. Kelly of Detroit gave the scientific address of the evening.

One of the high points of the evening was the excellent singing of Mr. Jack Moldowan, who entertained through the courtesy of Cottrell-Clarke, Inc., of Detroit, an exhibitor.

Mr. Frank M. Rhatigan, secretary of the Medical Exhibitors Association, Danbury, Connecticut, attended the Michigan State Medical Society convention as official representative of his association. Mr. Rhatigan expressed great appreciation for the courtesies extended by the M.S.M.S. members to the exhibitors.

The lucky winners of DeLuxe Traveling Kits, presented by the Mennen Company in booth number 48, were Drs. Albert Bernstein, R. W. Cavell, H. W. Hewitt, Scipio Murphy and Wm. J. Stapleton, Jr., all of Detroit, and Joseph L. Baer, M.D., of Chicago, Ill.

Coca-Cola dispensed 2,329 bottles of their product to thirsty physicians and guests during the three days of the Convention.

The Radio Committee of the Michigan State Medical Society sponsored the following talks during the Convention of the Society in Detroit, September 19-20-21-22:

September 19

Clark D. Brooks, M.D., WJR—What the Michigan State Medical Society is Accomplishing.
Gene Osius, M.D., WEXL—Surgery.
O. A. Brines, M.D., CKLW—Cancer.
Louis A. Schwartz, M.D., CKLW—Discipline of the Child in the Light of the Intra-Family Relationship.
J. E. G. Waddington, M.D., WEXL—Is Medical Care Inadequate? If so, Why?

September 20

Morris Fishbein, M.D., WWJ—The Discussion of Modern Social Trends in Medical Practice.
B. R. Corbus, M.D., CKLW—New Plans in Medicine.
A. D. Ruedemann, M.D., WJR—Conservation of Vision.
Roger S. Siddall, M.D., WEXL—Maternal Health.
Paul McQuiggan, M.D., CKLW—County Aid in Medical Care.
Harry S. Berman, M.D., WEXL—The Common Cold.

September 21

Ralph H. Pino, M.D., WJR—Distribution of Medical Care to the American People.
F. T. Andrews, M.D., WEXL—Development in Modern Surgery.
Martin H. Hoffmann, M.D., CKLW—Patients Also Treat Doctors.
C. E. Umphrey, M.D., CKLW—The Place of Organized Medicine in Wayne County.
W. L. Quennell, M.D., WEXL—The Role of the American Hospital.

September 22

Henry Cook, M.D., CKLW—The Progressive Attitude of American Medicine.
Henry R. Carstens, M.D., WJR—The Dissemination of Medical Knowledge.
Wm. J. Stapleton, Jr., M.D., WEXL—Ideals in Medicine.
Harry Pierce, M.D., WEXL—What is the Meaning of Prenatal Care.
M. H. Erickson, M.D., CKLW—Mental Hygiene.

The Radio Committee, through its chairman, Fred H. Cole, M.D., wishes to take this opportunity of thanking the above speakers for their splendid coöperation.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.

YOU CAN SLEEP WELL. THE A B C's OF RESTFUL SLEEP FOR THE AVERAGE PERSON. By Edmund Jacobson, M.D. New York, Whittlesey House, London: McGraw-Hill Book Company, Inc., 1938, $2.00.

CHALLENGE TO SEX CENSORS. By Theodore Schroeder. Privately printed to promote the aims of the Free Speech League, New York City, 1938.

SYPHILIS, GONORRHEA, AND THE PUBLIC HEALTH. By Nels. A. Nelson, B.S., M.D., F.A.P.H.A., Director, Division of Genitoinfectious Diseases, The Massachusetts Department of Public Health, and Gladys L. Crain, R.N., Epidemiologist, Division of Genitoinfectious Diseases, The Massachusetts Department of Public Health. New York: The MacMillan Co., 1938.

ANUS, RECTUM, SIGMOID, COLON: DIAGNOSIS AND TREATMENT. By Harry Ellicott Bacon, B.S., M.D., F.A.C.S., F.A.P.S. Assistant Professor of Proctology, Temple University, School of Medicine. Introduction by W. Wayne Babcock, A.M., M.D., L.L.D., F.A.C.S., Professor of Surgery, Temple University School of Medicine. Forword by J. P. Lockhart-Mummery, M.A., M.B., B.C. (Cantab), F.R.C.S. (Eng.). Emeritus Surgeon, St. Mark's Hospital, London, England. 487 illustrations in the text mostly original by William Brown McNett. Philadelphia, Montreal, London: J. B. Lippincott Co.

HUMAN PATHOLOGY, A TEXTBOOK. By Howard T. Karsner, M.D., Professor of Pathology, Western Reserve University, Cleveland, Ohio. With an introduction by Simon Flexner, M.D. 18 illustrations in color and 443 in black and white. Fifth edition, revised. Philadelphia & London: J. B. Lippincott Co.

OUTLINE OF ROENTGEN DIAGNOSIS. An Orientation in the Basic Principles of Diagnosis by the Roentgen Method. By Leo. G. Rigler, B.S., M.B., M.D. Professor of Radiology, University of Minnesota, Minneapolis, Minnesota. Atlas Edition, 254 illustrations shown in 227 figures, presented in drawings and reproductions of roentgenograms. Figures 6 to 51 and 55 to 72 are drawings in an original technic by Jean J. Hirsch, Philadelphia, London, Montreal, New York: J. B. Lippincott Co.

THE COMPLEAT PEDIATRICIAN. By Wilburt C. Davison, M.A., D.Sc., M.D. Professor of Pediatrics, Duke University School of Medicine, and Pediatrician, Duke Hospital. Acting Pediatrician in charge, The Johns Hopkins Hospital. Fellow American Academy of Pediatrics and American College of Physicians. Member White House Conference, American Pediatric Society, and American Board of Pediatrics. Second completely rewritten edition. Durham, N. C.; Seeman Printery for Duke University Press, 1938.

The title is adapted from the "The Compleat Angler" by Isaak Walton. This work deals with practical, diagnostic, therapeutic and preventive pediatrics and is especially recommended as a quick reference for medical students, internes, general practitioners and pediatricians. The author makes an up-to-date digest of the vast amount of pediatric literature accumulated during the past four years in the various journals. Indications for the use of the relatively recent "panacea," sulphanilamide, are included.

Chapters on growth and development, laboratory procedures, and infant feeding and child nutrition are noteworthy, particularly the former, in as much as the average physician overlooks the fundamentals of normal growth and development of the child's mental as well as physical processes. Thorough understanding of these is essential for a true appraisal of the growing child. Several pages are devoted to drugs and prescriptions commonly used in pediatric practice. In all, a large field has been ably handled in a clever and concise manner in this small book which should appeal to the progressive physician.

PEDIATRIC SURGERY. By Edward C. Brenner, A.B., M.D., F.A.C.S Director of Surgery, Riker's Island Hospital; Director of surgery, Detention Hospital; Attending Surgeon, Midtown Hospital, Associate Professor Clinical Surgery, New York Post-graduate Medical School, Columbia University; Associate Attending Surgeon and Chief of Clinic, Post-graduate Hospital; Consulting Surgeon, Hunt's Point Hospital; Fellow of American Medical Association, American College of Surgeons. New York Academy of Medicine; former Surgeon, Squadron A. Illustrated with 293 engravings. Philadelphia: Lea and Febiger, 1938.

Pediatric surgery is now an accepted branch of general surgery and it seems timely to have a book correlating the affections peculiar to childhood and the treatment thereof. We recognize differences in certain diseases in the child and in the adult and many conditions seen in childhood are uncommon or are not seen at all in adult surgery, especially the congenital deformities. However, it is not so much the differences in the manifestations of the disease processes in the two as it is the judicious handling of the more delicate situation in the infant or child that demands most attention. Particularly, must the pediatric surgeon bear in mind that his patient's body is no place for heroic surgery.

In this book, the author has responded to a request by students for a text on surgery of infants and children. Most texts on general surgery already include this more limited field but do not cover it so completely, nor so well.

Fractures, dislocations and orthopedic conditions have rightly been omitted to allow for more discussion of the other surgical subjects. Many operations are described in detail and the essentials of pre- and post-operative treatment are emphasized.

Six specialists have contributed noteworthy chapters on anesthesia, blood transfusions, congenital cleft lip and palate, thoracic surgery, urology, and neurologic surgery, all of which add considerable to the value of the book.

THE FIGHT FOR LIFE. By Paul DeKruif, Book-of-the-Month Club selection, published by Harcourt-Brace and Company, Inc., 383 Madison Avenue, New York.

A book written in extremely interesting fashion. One may not always agree with the writer in his conclusions. It does challenge the reader, if he is a medical man, to give interest to and do his best.

H. C.

ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY of the American Medical Association for 1937, with the Comments that Have Appeared in The Journal. Cloth. Price, $1.00. pp. 201. Chicago: American Medical Association.

This book is a great deal more than a mere record of the negative actions of the Council on Pharmacy and Chemistry. It gives in full the reasons for the Council's rejection of various preparations, but it also records results of the Council's investigations of new medicinal agents not yet out of the experimental stage, and frequently contains reports on general questions concerned with the advance of rational drug therapy. All three categories of reports are represented in the present volume.

This issue of the Reports is remarkable for the series of valuable status and preliminary reports published by the Council in the past year. These include the reports on Avertin with Amylene Hydrate (now accepted for New and Nonofficial Remedies), Benzedrine Sulfate (the active constituent of the notorious "pep" pills but a promising drug when its limitations are recognized), Catgut Sutures (a survey of the sterility of the market supply), Evipal Soluble (a comprehensive review of the evidence for the usefulness and limitations of the drug), Histidine Hydrochloride (a study of the usefulness of the drug in peptic ulcer, to be considered in connection with the report rejecting

Larostidin, a proprietary brand, for unwarranted and exaggerated claims), Mandelic Acid (an authoritative statement of the limitations of this drug which the Council has now accepted), and Vinethene (a careful study of the evidence for the drug, which the Council has accepted for one year as an anesthetic to be used in short procedures).

Other notable reports of outright rejection of products are those on Causalin (Causyth), an unsafe and dangerous preparation proposed for use in arthritis; Glutamic Acid Hydrochloride-Calco, proposed as a conveyor of hydrochloric acid, with unsubstantiated claims of clinical effectiveness; Larodon "Roche," proposed as a substitute for other well established analgesic and antipyretic drugs and marketed with exaggerated and unwarranted claims.

Two reports on Sulfanilamide appear, a nomenclature and status report together with reprints of *The Journal* editorials giving the warnings which, if obeyed, would have avoided the series of deaths which resulted from the marketing of the ill-fated Elixir of Sulfanilamide-Massengill.

At the end of this volume appears a eulogy of George Henry Simmons, whose death deprived the Council on Pharmacy and Chemistry of its founder and American medicine of a worthy and faithful servant.

AMONG OUR CONTRIBUTORS

Dr. Samuel S. Altshuler was graduated from the University of Michigan Medical School in 1925. He specialized in Internal Medicine. He was formerly instructor in the Department of Internal Medicine, University of Michigan College of Medicine. He is Assistant Physician to the Out-Patient Department of Harper Hospital; Attending Physician at William J. Seymour Hospital, Eloise, Michigan; Clinical Instructor in Internal Medicine, Wayne University College of Medicine. He is a Fellow of the American College of Physicians.

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S. Stephen Bohn, M.D., is Instructor in Neurology and Psychiatry, Wayne University, College of Medicine. He is Assistant Physician in Neurology, Harper Hospital, Detroit. The remainder of biography was submitted previously with a manuscript entitled "An Analysis of the Contribution Made by Pneumencephalography to Neurological Diagnosis" which was printed in THE JOURNAL of the Michigan State Medical Society, March, 1938.

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Dr. H. L. Burkholder was graduated from the Johns Hopkins Medical School in 1916. He is a general practitioner in Alpena, Michigan.

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Dr. David B. Davis was graduated from the University of Michigan Medical School in 1927. He is a diplomate of the American Board of Psychiatry and Neurology.

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Arthur J. Derbyshire, Jr., Ph.D., is Assistant Professor in Neuro-anatomy, Department of Anatomy, Wayne University, College of Medicine. He was graduated A.B. at Harvard in 1930, and Ph.D. at Harvard in 1935 in Medical Physiology. His publications are:

(1) Derbyshire, A. J., and Davis, H.: "The Action Potentials of the Auditory Nerve," Amer. Jour. Physiol.; vol. 113, pp. 476-504, 1935.

(2) Derbyshire, A. J., Rempel, B., Forbes, A., and Lambert, E. F.: "The Effects of Anesthetics on Action Potentials in the Cerebral Cortex of the Cat," Amer. Jour. Physiol., Vol. 116, pp. 577-596, 1936.

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Dr. Haven Emerson was graduated from the Columbia Medical School in 1899. He was Assistant in Medicine at Columbia from 1906 to 1910. From 1915 to 1917, he was Commissioner of Health and President of the Board of Health of New York City. He served a year as Professor of Hygiene and Preventive Medicine at Cornell, and later as Professor of Public Health Administration and Director of the DeLamar Institute of Public Health at the College of Physicians and Surgeons of Columbia University. In 1929, he went to Athens, Greece, for the Survey of Health and Sanitation for the League of Nations and in 1931, he was a member of the National Advisory Health Council. Dr. Emerson was also a member of the Committee of Expert Statisticians of the League of Nations.

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Miss Betty N. Erickson received the M.S. degree from Stanford University in 1932. She is an Associate in Research at the Research Laboratory of the Children's Fund of Michigan.

* * *

Dr. Rudolph Leiser was graduated from the Frederick Wilhelm University Medical College, Breslau, Germany, in 1927. He has been Research Fellow in the department of Internal Medicine at the William J. Seymour Hospital, Eloise, Michigan. He is an Associate Fellow of the American College of Physicians.

* * *

Dr. T. Leucutia received his M.D. from the University of Bucharest in 1916, C.E.R., from the University of Paris in 1920 and D.M.R.E. from the University of Cambridge in 1921. He is Associate Radiologist at Harper Hospital, Detroit.

* * *

Dr. Dayton H. O'Donnell received his B.S. degree from St. Louis University in 1925, and M.D. in 1927. He spent his interneship at Providence Hospital, Detroit, from 1927 to 1928 and the following year served as Surgical Resident at the same hospital.

* * *

Dr. Marsh W. Poole was graduated from the University of Western Ontario in 1923. He is an instructor in Pediatrics at Wayne University College of Medicine and his specialty is pediatrics.

* * *

Dr. Geza Schinagel is a graduate of the University of Budapest, 1919. From 1914 to 1918 he was in the field medical service in the Austrian-Hungarian Army. The following two years he was connected with the St. Margareth Hospital in Budapest. Since 1924, Dr. Schinagel has been in the Division of Urology at the City Physician's Office in Detroit.

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All communications relative to exchanges, books for review, manuscripts, should be addressed to J. H. Dempster, M.D., 5761 Stanton Avenue, Detroit, Michigan.

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